



THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

**Relationship Violence and Non-Partner Sexual Violence among Young People
and Young Adults in New York City: Implications for Practice**

Deborah Ann Fry

PhD by Publications

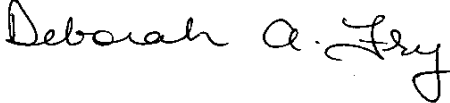
The University of Edinburgh

May 2015

Declaration

I, Deborah Ann Fry, certify that I have composed this thesis and publications herein and that I have made a significant contribution to the research and writing of any joint publications as specified within this thesis. I also certify that this work has not been submitted for any other degree or professional qualification.

Signature:

A handwritten signature in black ink that reads "Deborah A. Fry". The script is cursive and fluid, with the first name "Deborah" and last name "Fry" being clearly legible, and the middle initial "A." written in a smaller, simpler script.

Date: 20 May 2015

Acknowledgements

I would like to thank the researchers at the Columbia Center for Youth Violence Prevention (CCYVP) at the Mailman School of Public Health: Professor Leslie Davidson and Dr. Vaughn Rickert, as well as Bruce G. Link, the Director of CCYVP at Columbia University. Your mentorship was invaluable and your commitment to ending violence among young people in NYC is inspiring.

Special thanks to everyone at the New York City Alliance Against Sexual Assault especially to my co-workers, the volunteers, and interns, who provided me with a supportive and engaging environment within which to carry out this research. I was and am continually inspired by your dedication to evidence-based research and improving the responses to and prevention of sexual violence in NYC. Some of my happiest and most inspired moments include working alongside all of you. I am especially grateful for the vision, guidance and support of Harriet Lessel, the former Executive Director of the New York City Alliance Against Sexual Assault.

A warm thank you goes to the 13 participating rape crisis programme sites for the 'Room of Our Own' study and their staff for working on the often-cumbersome institutional Review Board protocols, training, and data collection processes. Your tireless effort to improve services for survivors is to be applauded.

I also wish to give special thanks to Susan Xenarios; an inspirational pioneer of the rape crisis movement in New York City, and a personal mentor who has been a valuable guide throughout my work in this field.

Of course, additional thanks are due to all who participated in these studies, without whom this research and these reports would not have been possible. These young people, women and men showed great courage in sharing their experiences with me. I am especially grateful for the students who assisted in developing and piloting the survey questionnaires for the 'Partners and Peers' study.

I wish to acknowledge the many helpful staff members of The New York State Department of Health, The New York State Department of Criminal Justice Services, the New York City Department of Education, the schools involved in the 'Partners and Peers' study, and key stakeholders from the four sectors involved in these studies: Hospital services, rape crisis programmes, law enforcement and criminal justice services, who provided me with excellent feedback on my research.

Very warm thanks to Professor Lani Florian, my PhD supervisor, for all her support and encouragement throughout the process. You are an amazing mentor. A special thanks to Dr. Anne Stafford, a former colleague who encouraged me to pursue the PhD by Publications route. Your dedication to child protection continues to inspire me to be the best researcher I can be. Special thanks also to my current line manager, Dr. Gillean McCluskey for her support and guidance, which has helped me stay centred in my beliefs and values.

Finally, a very special thanks to the Research Advisory Board, consisting of amazing researchers in this field, who consistently challenged and supported me, taught me how to maximise evidence for policy and programmatic implementation and who advocated for all the studies included in this portfolio of work. You all inspired me to strengthen my roots, build my passion for research in this area and to hone my skills in order to build evidence and impact.

Dedication

I would like to dedicate this thesis to my loving and supportive husband, David, who has been a rock for me during a very busy and often crazy time. Thank you for everything that you do to support and nurture me! I love you so much. Also, warm loving thanks to my mom and dad for their constant support and always encouraging and supporting their little girl to dream big and to always follow her heart. I love you all.

Abbreviations

ACASI	Automated Computer Assisted Self Interviewing
ANOVA	Analysis of Variance
AOR	Adjusted Odds Ratio
ARV	Adolescent Relationship Violence
CADRI	Conflict in Adolescent Dating Relationship Inventory
CHIP-AE	Child Health and Illness Profile–Adolescent Edition
CI	Confidence Interval
CSA	Child Sexual Abuse
CSEC	Commercial Sexual Exploitation of Children
DVI	Dating Violence Inventory
ED	Emergency Department
FDNY	Fire Department of New York
IT	Intimate Terrorism
IPV	Intimate Partner Violence
LGBT	Lesbian, Gay, Bisexual and Transgender
MAR	Missing at Random
MVC	Mutual Violent Control
NV	Non-Violent
NYC	New York City
NYS	New York State
OR	Odds Ratio
PEP	Post-Exposure Prophylaxis
QA	Quality Assurance
REF	Research Excellence Framework
REMAC	Regional Emergency Medical Advisory Committee
REMSCO	Regional Emergency Medical Services Council of New York City
SAFE	Sexual Assault Forensic Examiner
SART	Sexual Assault Response Team
SCV	Situational Couple Violence
SV	Sexual Violence
USC	Unilateral Situational Violence
UVC	Unilateral Violent Control
VC–VR	Violent Control–Violent Resistance
VR	Violent Resistance
WHO	World Health Organization
YAC	Young Adult Clinic sample
YRBS	Youth Risk Behavioural Survey

Table of Contents

Acknowledgements	3
Dedication	5
Abbreviations	6
Abstract	9
1.0 Introduction to the Critical Review	11
1.1 Aims and Objectives of the Body of Work	14
1.2 Rationale and Significance of the Body of Work	14
2.0 A Critical Review of the Literature from the Body of Work	16
2.1 A Critical Review of the Literature on Measuring Prevalence	16
2.2 A Critical Review of the Literature on Measuring Outcomes	17
2.3 A Critical Review of the Literature on Measuring Service Provision	18
2.4 A Critical Review of the Literature on Translating Research into Policy and Practice	20
3.0 A Critical Review of the Methods in the Body of Work	21
3.1 The Ethical Considerations in the Body of Work	21
3.2 A Critical Review of the Theoretical and Conceptual Models in the Body of Work	23
3.3 A Critical Review of the Measures Used in the Body of Work	25
3.4 A Critical Review of the Statistical Methods Conducted in the Body of Work	27
3.5 Validity and Generalizability	28
4.0 A Critical Review of the Findings in the Body of Work	32
4.1 Prevalence of Adolescent Relationship Violence and Non-Partner Sexual Violence	32
4.2 Nature of Adolescent Relationship Violence and Non-Partner Sexual Violence	35
4.2.1 Adolescent Communication	35
4.2.2 Nature of Help-Giving and Help-Seeking Behaviours	37

4.3	Impact of Relationship Violence and Non-partner Sexual Violence on Young People's Health and Well-being	39
4.4	Mapping Acute Care Services for Sexual Violence in NYC	40
4.5	Survivors' Perspectives on their Level of Satisfaction with Services in NYC	41
5.0	Recommendations for Response and Prevention	43
6.0	Contributions of the Body of Work	45
6.1	My Contributions to the Research and Published Body of Work	46
7.0	Conclusion	49
	References Cited in the Critical Review	50
	Publications in the Body of Work	59
Appendices		
	Appendix 1: Literature Review Components within the Body of Work	59
	Appendix 2: Summary of Validated Instruments Used in the Body of Work	61
	Appendix 3: Summary of Newly Developed Scale Measures in the Body of Work	65
	Appendix 4: Summary Overview of Data Analyses Conducted in the Body of Work	68
	Appendix 5: Summary Overview of Missing Data for Key Analyses	71
Tables		
	Table 1: Summary of Ethical Considerations and Procedures in the Body of Work	22
	Table 2: Theoretical and Conceptual Models Explored in/Underpinning the Body of Work	23
Figures		
	Figure 1: The Public Health Model Framework for PhD Body of Work	25
	Figure 2: Experiences of Non-partner and Partner Sexual Violence among High School Students from the Partners and Peers Study	32
	Figure 3: Self-reported Adolescent Relationship Violence Behaviours	33
	Figure 4: Percentage of Young People who Report Ever Experiencing Physical or Sexual Relationship Violence Behaviours	34

Abstract

The six research papers and journal articles that form this submission all focus on the nature of and response to young people and young adults who have experienced relationship violence and non-partner sexual violence in New York City (NYC).

These six empirical papers are based on three primary research studies in which I was the Principal Investigator spanning four years of research work:

- A quantitative study of 1,312 young people in NYC high schools,
- A survey of 65 survivors of sexual violence about their experiences with services (hospital, counselling, police and criminal justice) in NYC, and
- A comprehensive survey of 39 emergency departments in NYC about acute care provision for sexual assault patients.

These studies are innovative in that all three are ‘firsts’ in the field of violence prevention and response:

‘Partners and Peers’ was the first study of its kind to explore the prevalence of sexual and dating violence in NYC amongst high school students. This study found that 16.2% or more than 1 in 6 students surveyed reported experiencing sexual violence at some point in their lives. Of these youth, 10.1% reported experiencing non-partner sexual violence (sexual abuse or forced sex), and 14.1% reported experiencing sexual violence from a dating partner. The survey was available in both Spanish and English (both versions translated and back-translated). Passive parental consent and student assent were obtained with parental consent letters available in English, Spanish and Chinese. Three ethical review boards, including the NYC Department of Education, approved this study.

‘A Room of Our Own’ was the first study to explore from survivors’ own perspectives their satisfaction with the care and support they received post-assault in NYC with the majority of respondents having experienced a sexual assault under the age of 25 (study was approved by eight Ethics Review Boards), and

‘How Safe is NYC’ was the first study to comprehensively map protocols, procedures and services offered across Emergency Departments in NYC including how adolescent patients are treated.

All three of these studies garnering significant media coverage which appeared in the New York Sun, The Washington Post, the New York Post, The New York Daily News, El Diario and on CBS news (TV) and WBAI radio.

Three of the six submitted publications have already been ranked internally as part of the Moray House School of Education’s REF submission (my 4th REF submission was another journal article on a different area of child protection) and they have all been recognised as internationally excellent in terms of originality, significance and rigour.

This body of work has had and continues to have significant implications for practice as highlighted in this thesis. The study of survivors’ perspectives and acute care responses in emergency departments led directly to a change in New York State Law for ambulance destination designation and a commitment from the NYC Mayor for Sexual Assault Forensic Services in all public NYC hospitals. The school-based study findings also directly led the NYC Chancellor to change the disciplinary regulations in all New York City high schools in relation to adolescent relationship violence.

This research highlights the need for practitioners, policymakers and researchers to better understand the nature of relationship violence and non-partner sexual violence among adolescents and young adults in New York City in order to develop evidence-informed programmes and policies for prevention and response.

1. Introduction to the Critical Review

Relationship violence and non-partner sexual violence is a public health concern globally. A recent global meta-analysis found that in 2010, 30.0% (95% CI: 27.8, 32.2) of women aged 15 and over have ever experienced some form of physical and/or sexual intimate partner violence (Devries et al., 2013). Non-partner sexual violence global estimates range from 3.3% to 21% of women experiencing some form of sexual assault from someone other than an intimate partner (WHO et al., 2013). In North America, the prevalence of non-partner sexual violence is 13.01% (95% CI: 9.02, 16.99) (WHO et al., 2013).

In the United States, adolescents between the ages of 12 and 19 are sexually assaulted at rates higher than other age groups (Catalano, 2004). A recent national study of children conducted in the United States found that two percent of all the children surveyed had experienced sexual assault or sexual abuse in the last year, with a rate of 10.7% for girls aged 14 to 17 years old (Finkelhor et al., 2013). In NYC, 10% of females and 5% of males reported ever being forced to have sex and dating violence was reported in the past year by 11% of females and 9% of males (Olshen et al, 2007). Looking at this Youth Risk Behavioural Surveillance System data nationally shows that one in 11 adolescents reports being a victim of physical dating aggression each year (CDC, 2006).

Relationship violence and non-partner sexual violence among young people and young adults remains a hidden epidemic in NYC. The body of published work in this PhD by Publications thesis aims to increase our understanding of the prevalence, nature and impact of relationship violence and non-partner sexual violence as well as the responses available to these populations. This data was used to advocate for policies, programmes and services for prevention and response.

This body of work encompasses the following peer-reviewed publications based on data from three studies exploring relationship violence and non-partner sexual violence in NYC:

1. O'Sullivan, C. and Fry D. (2007). *Sexual Assault Victimization Across the Lifespan: Rates, Consequences and Interventions for Different Populations*. Victims of Crime, RC Davis, A. Lurigio & S. Herman, editors, 3rd edition. London: Sage.
2. Fry, D.A., Davidson, L.L., Rickert, V.I. and H. Lessel (2008). *Partners and Peers: Sexual and Dating Violence Among NYC Youth*. A Research Report by the NYC Alliance against Sexual Assault in Conjunction with the Columbia University Centre for Youth Violence Prevention. New York City Alliance Against Sexual Assault: New York.
3. Messinger, A.M., Rickert, V.I., Fry, D.A., Lessel, H. and Davidson, L.L. (2012). Revisiting the Role of Communication in Adolescent Intimate Partner Violence. *Journal of Interpersonal Violence*, 27(14): 2851-2866.
4. Fry, D. Messinger, A.M., Rickert, V.I., O'Connor, M.K., Palmetto, N., Lessel, H., and Davidson, L.L. (2014) Adolescent Relationship Violence: Help-Seeking and Help-Giving Behaviors among Peers. *Journal of Urban Health*, 91(2): 320-334.
5. Fry, D. (2007). *How S.A.F.E. is NYC? Sexual Assault Services in Emergency Departments*. New York City Alliance Against Sexual Assault: New York.
6. Fry, D. (2007). *A Room of Our Own: Survivors Evaluate Services*. New York City Alliance Against Sexual Assault: New York.

The rationale for inclusion of these six publications is that they form a coherent body of research underpinned by a public health conceptual framework. These publications highlight that adolescents and young people are a very important group – both in terms of identifying the scope of violence but also in developing appropriate responses – because they often sit within the gap of the ‘adult’ sexual violence and domestic abuse fields and the child abuse fields. Thus, this critical review utilises the public health model in analysing the six publications to highlight the continuum of violence and also the gaps that exist in order to make a contribution to the field of violence prevention and response.

In accordance with the guidelines for the PhD by Publications, this short critical review will summarise the aims, objectives, methodology, results and conclusions covered by all the submitted work in the portfolio and will also indicate how the publications form a coherent body of work, my contribution to this work and how the work contributes significantly to the expansion of knowledge. The publications included in the body of work are presented in their entirety at the back of the critical

review in the order listed above. Copyright approval and permissions from all co-authors has been obtained to present and archive the publications in their entirety in this PhD thesis. Additional summary tables are included as an appendix to the thesis.

This research was undertaken (2004-2008) during a time of extensive inquiry into adolescent relationship violence in the United States. Consistent findings were emerging during this time of unexpectedly high rates of female-perpetrated violence against their male partners. This was highly controversial in both academic and practitioner spheres, with practitioners questioning scholars on the theoretical basis of research (e.g. whether feminist theories of the nature of violence against women and the presence of patriarchy were being dismissed in the research) (Anderson, 2005; Dobash & Dobash, 2004; Dutton & Nicholls, 2005) to debates on the sex differences in perpetration of intimate partner violence (Archer, 2000; Caetano et al., 2009; Simpson & Christensen, 2005; Strauss, 2011) to debates on how we measure and conceptualise adolescent relationship violence (Reed et al., 2010; Stark, 2010).

This work very much sits within that time period and continues to contribute to these debates. Terminology has been consciously chosen and has evolved over the time period of the publications. The term ‘adolescent relationship violence’ is used in this critical review and later publications to recognise that many adolescents may not use the term ‘dating’ to describe their relationships and to also distinguish this age group from the adult ‘intimate partner violence’ research. Similarly, later publications in this body of work also move away from the terms ‘victim’ and ‘perpetrator’ of violence to ‘violence used’ and ‘violence received’ to highlight that the current ways of measuring prevalence do not always give us the full context or order of events surrounding violence. This does not in any way undermine the clear and widely accepted understanding that the impact of relationship violence falls primarily on women who suffer the majority of severe forms of violence. As such, terms such as gender symmetry are avoided while still allowing rigorous analytical questioning of findings on the nature of adolescent relationships and how we conceptualise adolescent relationship violence.

1.1. Aims and Objectives of the Body of Work

This body of work, which encompasses three studies, aims to explore the magnitude and nature of relationship violence and non-partner sexual violence and to understand the availability, quality and nature of informal and formal support and survivors' satisfaction with a range of services for relationship violence and non-partner sexual violence.

Objectives

In pursuit of this aim the objectives of this body of work were:

1. To explore the prevalence of high school students' experiences of relationship violence and non-partner sexual violence,
2. In addition, to explore students' reflections and experiences of the nature and impact of relationship violence and non-partner sexual violence on their lives and their ideas for preventing these abuses among young people,
3. To map the specific acute care services available at New York City's emergency departments for sexual assault survivors,
4. To gather survivors' own perspectives on their level of satisfaction with services available in New York City (hospital, rape crisis, police and district attorney), and
5. Based on data collected from young people and young adults, to make recommendations for improving both the prevention of and response to relationship violence and non-partner sexual violence in New York City.

1.2. Rationale and Significance of the Body of Work

New York City has a population of over 8 million people and is one of the largest cities in the world (U.S. Census, 2000). It has and continues to be at the forefront of service provision for relationship violence and non-partner sexual violence with the first Special Victim's Unit set up as part of a police force and the first Sex Crimes Unit within a District Attorney's Office specifically for sexual violence. Applying national prevalence estimates from the CDC's National Intimate Partner and Sexual Violence Survey to the NYC population, it is estimated that over 813,000 female and 64,500 male New Yorkers have been raped during their lifetime and 1.8 million

female New Yorkers and nearly 888,000 male New Yorkers have experienced other forms of sexual violence during their lifetimes, including being made to penetrate, sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences with the vast majority of these experiences occurring under the age of 25 (Breiding et al., 2014).

Despite the prevalence of relationship violence and non-partner sexual violence, very little primary research has been conducted within NYC on the nature and impact of violence and the provision of and satisfaction with services for violence as experienced by young people and young adults.

These studies included in this body of work representative innovative ‘firsts’ in the field of sexual violence and relationship violence in NYC:

- ‘Partners and Peers’ was the first study of its kind to explore the prevalence of sexual and dating violence in NYC among high school students.
- ‘A Room of Our Own’ was the first study to explore from survivors’ own perspectives, their satisfaction with the care and support they received post-assault in NYC with the majority of respondents having experienced a sexual assault under the age of 25, and
- ‘How Safe is NYC’ was the first study to comprehensively map protocols, procedures and services offered across Emergency Departments in NYC including how adolescent patients are treated.

All three of these studies garnered significant media coverage, which appeared in the New York Sun, The Washington Post, the New York Post, The New York Daily News, El Diario and on CBS news (TV) and WBAI radio.

2. Critical Review of the Literature in the Body of Work

The six publications in the body of work provide significant coverage of the area of adolescent relationship violence and non-partner sexual violence in NYC with over 400 references to literature on the topic. The topics covered in the review of the literature across the body of work are highlighted in Appendix 1 with the corresponding publication and page numbers. The relevant literature, with a specific focus on NYC, is presented for each of the objectives of the body of work.

A Critical Review of Literature on Measuring Prevalence

For the first objective on measuring the prevalence of adolescent relationship and non-partner sexual violence in NYC, a review of global, national and local prevalence studies was conducted. Studies were also reviewed in sub-areas of relationship violence and non-partner sexual violence including child sexual abuse, commercial sexual exploitation, sexual victimisation of young people, and youth violence, amongst others. Relationship violence and non-partner sexual violence are also reviewed across the lifespan to understand better the prevalence estimates among young people and young adults.

The measurement of relationship violence and non-partner sexual violence against adolescents represents one of the most serious challenges in the victimisation field as it is often hidden, unreported and under-recorded (Pinheiro, 2006). Both relationship violence and non-partner sexual violence are seen as stigmatizing and shameful, which can make it difficult for survivors to share their stories (Dartnall & Jewkes, 2012). Adolescents are in especially vulnerable positions as the perpetrator of the violence may be a partner, parent, family member, caretaker, service provider or significant figure in the community and victims are often coerced or threatened into not telling. Adolescents particularly may be afraid of getting into trouble and disclosure of experiences has very real consequences including separation from family, rejection from community members and peers, punishment, withdrawal of services and even exposure to further violence and these experiences may impact on their willingness to disclose or seek further help (Fehler-Cabral & Campbell, 2013).

The violence prevention field is confronted with many challenges for measurement,

which is reflected in the variation of prevalence estimates presented in the literature. Research shows that the differences in prevalence estimates may be due in part to methodological variation between studies. Sampling designs in addition to the type of respondent (adult, child) and methodological issues related to the implementation of the survey procedures, including the selection and levels of training of interviewers, and ensuring appropriate support of respondents and interviewers, have ethical implications and have also been shown to influence levels of disclosure within prevalence surveys (WHO, 2013; CPMERG, 2012; Ji, Finkelhor & Dunne, 2013; Dartnall & Jewkes, 2012).

Higher levels of prevalence are found in surveys when questions are framed around behaviourally specific acts instead of relying on terms such as ‘violence’ or ‘abuse’ which can be subjective given social norms such as has been done in the ‘Partners and Peers’ study (Dartnall & Jewkes, 2011). Furthermore, respondents may be disclosing violence for the first time through research. For example, in the World Health Organization’s Multi-country Study on Violence Against Women, between one fifth and almost one half of the female respondents reporting violence, the survey interviewer was the first person disclosed to about those experiences (Jansen et al., 2004). This highlights that many surveys on violence, especially those that measure relationship violence and non-partner sexual violence, may still be underestimating the true prevalence of the violence experiences of the respondents (Ellsberg et al., 2001).

Another factor that may cause errors in estimating prevalence is the retrospective recall of adverse events in childhood. Research has shown that this can be due to several factors including recollection, subsequent experiences that may influence memories and not being able to remember the timing or specifics of traumatic events (Hardt & Rutter, 2004).

A Critical Review of Literature on Measuring Outcomes

For objective 2 of the body of work, the literature review examined the nature and impact of adolescent relationship violence and non-partner sexual violence examining studies on adolescent communication, types of violent relationships, the health and well-being consequences of experiencing violence, theories and

definitions of relationship violence and non-partner sexual violence and literature on revictimisation.

One of the biggest challenges in estimating the consequences of violence exposure is the limitation of estimating causality. Most studies focused on adolescent relationship violence and non-partner sexual violence are mainly cross-sectional designs such as the 'Partners and Peers' study which can only examine associations between variables. Even with longitudinal designs, studies often don't measure all the potential confounders and are thus unable to control for other possible factors for the outcomes explanation, such as childhood adversity experiences (Fang et al., 2015). Another key factor when exploring the relationship between violence experiences and various outcomes is whether there is reverse causation, in other words, whether the violence is a cause or consequence of the outcome (Devries et al., 2013). While beyond the scope of the studies conducted in this body of work, these considerations are important to bear in mind when examining the outcomes related literature.

A Critical Review of Literature on Measuring Service Provision

Literature supporting objectives 3 and 4 of the body of work focus on the types of services available to survivors in NYC (including both child and adult survivors), the definition and measurements of satisfaction of various service sectors as well as the literature on help-seeking and help-giving behaviours.

A particularly salient aspect of the literature is around acute care responses to sexual violence. Sexual violence, from both intimate partners and non-partners, is a public health issue that presents important implications for clinical management. While forensic evidence collection is often the focus of post-assault care, sexual assault patients have additional medical needs such as injury detection and treatment, information about emergency contraception, screening and/or prophylaxis for sexually transmitted infections (STIs) and referrals for a range of therapeutic and support services.

Studies assessing the clinical management of sexual assault patients in the United States, Canada, England and South Africa have found high levels of inequality in health service provision. These data, including the 'How Safe is NYC' study in this body of work, indicates that there can be vast differences in clinician competencies, clinical practice, forensic evidence collection and institutional guidelines depending on where the sexual assault patient is seen (Fry, 2007; Lewis et al., 2003; Christofides et al., 2005; Azikiwe et al., 2005; Rosenberg, DeMunter & Liu, 2005; Kerr et al., 2003). Studies have also shown that adolescents often fall between the gaps of adult and child service provision as often both paediatric and adult services cater to this group (Horner et al., 2012; Ingemann-Hansen & Charles, 2013).

Many countries have instituted national strategies for the comprehensive acute care treatment of sexual assault patients to address these inequalities in provision of clinical care and forensic evidence collection identified through research. Most of these programmes focus on a one-stop shop for sexual assault patients, which include comprehensive medical care and forensic evidence collection (with or without reporting to the police) from specially trained clinicians and linkages to support services such as rape crisis counselling. A review of the evidence on the effectiveness of these programmes in the United States has found that they are effective across a number of outcome areas including: 1) promoting the psychological recovery of sexual assault patients, 2) providing comprehensive and consistent post assault medical care, 3) documenting the forensic evidence of the crime completely and accurately, 4) improving the prosecution of sexual assault cases by providing better forensics and expert testimony and 5) multi-agency collaboration by bringing multiple service providers together to provide comprehensive care to sexual assault patients (Campbell et al., 2008; Crandall & Helitzer, 2003; Ciancone et al., 2000; Martin et al., 2007).

By geographic comparison, England and Wales have recently taken the same approach as the United States and have set up Sexual Assault Referral Centres (SARCs) in every police jurisdiction. Early evaluations in England and Wales have shown strong multi-agency partnership working and a victim-centred approach to

providing services (Robinson, Hudson & Brookman, 2009). Scotland has one Sexual Assault Referral Centre in Glasgow (Archway). Baseline and follow-up data, such as the audit of provisions conducted through the 'How Safe is NYC' and the views and experiences of survivors through the 'A Room of Our Own' study are needed to better inform service organisation and to understand the current practice of clinical management, training and referral linkages that currently exist and the service user experiences of this practice.

A Critical Review of Literature on Translating Research into Policy and Practice

Finally, objective 5 of the body of work is related to developing recommendations based on findings. These recommendations are also rooted in the literature and cover various theoretical and conceptual models for prevention and response.

The body of evidence on effectively communicating and translating research results into policy and practice is growing rapidly. Key findings highlight the important role of communication and participatory study design at the outset with key policymakers and practitioners in order to ensure there is a common understanding of the policy and practice questions and of the scientific evidence needed to address them. Case studies conducted on translating research into policy found that researchers too often provide answers to questions in ways that are either not fully useful or meaningful to policy-makers (Samet & Lee, 2001). A special consideration within the field of violence prevention is the often sensitive nature of these questions to policymakers and even practitioners which highlights the importance of dialogue and relationship building between researchers, policymakers and practitioners early in the study design (Kothari et al., 2014). Learning from this field is expanded upon in the body of work.

3. Critical Review of Methods in the Body of Work

This body of work includes three separate quantitative studies with three differing methodologies. The ‘Partners and Peers’ Study (publications 2, 3 and 4) involved a survey in four high schools in New York City. Two of these high schools utilised a paper and pencil survey and two participated by using Audio Computer Assisted Self Interviewing (ACASI) as the mode of data collection. The ‘How Safe is NYC’ study (publication 5) consisted of face-to-face interviews with emergency department directors and clinical staff. The ‘A Room of Our Own’ study involved an anonymous online survey of survivors of sexual violence who had accessed services in NYC (publication 6). The methods of sampling and recruitment also varied greatly within each of these studies. Table 2 presents a summary overview of the designs for these three studies. Quantitative surveys were utilised for all three studies for the following reasons: 1) to measure the prevalence of relationship violence and non-partner sexual violence (‘Partners and Peers’ study), 2) to provide anonymity and confidentiality to participants around discussing these sensitive issues (‘A Room of Our Own’ study) and 3) to conduct and audit of existing facilities, services, policies and procedures (‘How SAFE is NYC’ study).

Each of the three studies involved formative research through consultation with key professional and research committees and groups as well as focus groups and in-depth interviews to help develop survey questions. All of the studies included piloting and testing of instruments and incorporation of findings from those pilot exercises into the final study design.

Like most research, this body of work is not without its limitations. Detailed discussions on the limitations and validity considerations for all the studies are included in the associated publications.

3.1 Summary of Ethical Considerations in the Body of Work

For the three studies included in the body of work, a total of 12 ethical review board approvals were obtained prior to undertaking the research. All the required ethical review approvals took approximately six to 12 months to obtain for each study.

Table 1: Summary of Ethical Considerations & Procedures in the Body of Work

	Partners and Peers Study	How Safe is NYC Study	A Room of Our Own Study
Ethical Review Board Approvals	Three review boards approved the study: 1) St. Luke's Roosevelt, 2) Columbia University and 3) NYC Department of Education	One review board approved the study: St. Luke's Roosevelt	Eight review boards approved the study: 1) St. Luke's-Roosevelt, 2) Harlem Hospital, 3) Safe Horizon, 4) Long Island College Hospital, 5) Mt. Sinai Medical Centre, 6) St. Vincent's Catholic Medical Center, 7) Beth Israel Medical Centre and 8) NYC Gay and Lesbian Anti-Violence Project
Consent Procedures	Passive parental consent, verbal student assent	Signed consent	Online 'digital' consent

Additional ethical considerations were also undertaken for each study including:

- **Timing:** For the 'Partners and Peers' study students were given the survey during health and PE classes and for students whose parents opted them out of the study, they were given alternative activities during the data collection time. Timing considerations were also thought out for the 'Room of Our Own' study to ensure that survivors were approached in an ethical way and service utilisation was not disrupted or compromised. For the 'How SAFE is NYC' study, timing considerations were taken into account for ED Directors and clinicians who had very busy call schedules in order to minimise the disruption of data collection on their clinical duties.
- **Confidentiality:** For the 'Partners and Peers' study, students were given plenty of space to take the survey such that other students would not be able to see their responses. Survey questions were also added to lengthen the survey so that those who had to answer more violence-related questions would not be identifiable by

the length of time it took for them to fill out the survey. For the ‘Room of Our Own’ study, sampling procedures and study design were designed to ensure anonymity of survey respondents.

- **Referral information:** All students in the participating high schools for the ‘Partners and Peers’ study were given referral information for sexual and relationship violence services and all data collectors were trained rape crisis advocates. In addition, all survivors who participated in the ‘Room of Our Own’ study were directed to online resources upon completion of the survey.

3.2 Critical Review of the Theoretical and Conceptual Models in the Body of Work

The six publications and two supplemental publications in the body of work cover a range of theoretical and conceptual models as highlighted in table 4, many of which are included in a recent review of theories related to relationship violence among young people (Dardis et al., 2014).

Table 2: Theoretical and Conceptual Models Explored in/Underpinning the Body of Work (with corresponding publication listed in the parentheses)

<i>Objectives</i>	<i>Theoretical/Conceptual Models</i>
<i>Objective 1: Prevalence</i>	Public health approach (1, 2, 5)
<i>Objective 2: Nature & Impact</i>	Public health approach (1, 2, 5) Feminist Theories (2, 5) Socio-ecological model (2) Social Learning Theory (2) Communication theory and strategies (3) Adolescent development (3)
<i>Objective 3: Acute Care Services</i>	Patient-centred care (6)
<i>Objective 4: Services & Survivors’ Satisfaction</i>	Quality assessment frameworks (5)
<i>Objective 5: Recommendations</i>	Public health approach (1, 2, 5) Spectrum of prevention (2) Socio-ecological model (2, Newly developed model for prevention coming out of body of work (2) Readiness for SV prevention (2) Peer help-giving models/bystander intervention models (4)

The current theories and frameworks for understanding violence prevention often don't take into account that adolescents sit between adult and child focused theoretical frameworks. This tension can also be seen in the emergence of 'Violence Against Women' (VAW) and 'Violence Against Children' (VAC) fields. This age/gender nexus related to adolescents can also be seen in the new emergence of the 'Violence Against Women and Girls' (VAWG) field. These differing age and gender focal points can create tensions in theory, policy and practice – particularly relating to adolescents. For example, young women in the age group 15–18 years experiencing non-partner sexual violence can also be considered, by some legal definitions, to have experienced child sexual abuse, as these are not mutually exclusive categories (WHO, 2013). Similarly, many theories designed to understand relationship and non-partner sexual violence among this age group adopt adult-centred theories of behaviour, norms and learning.

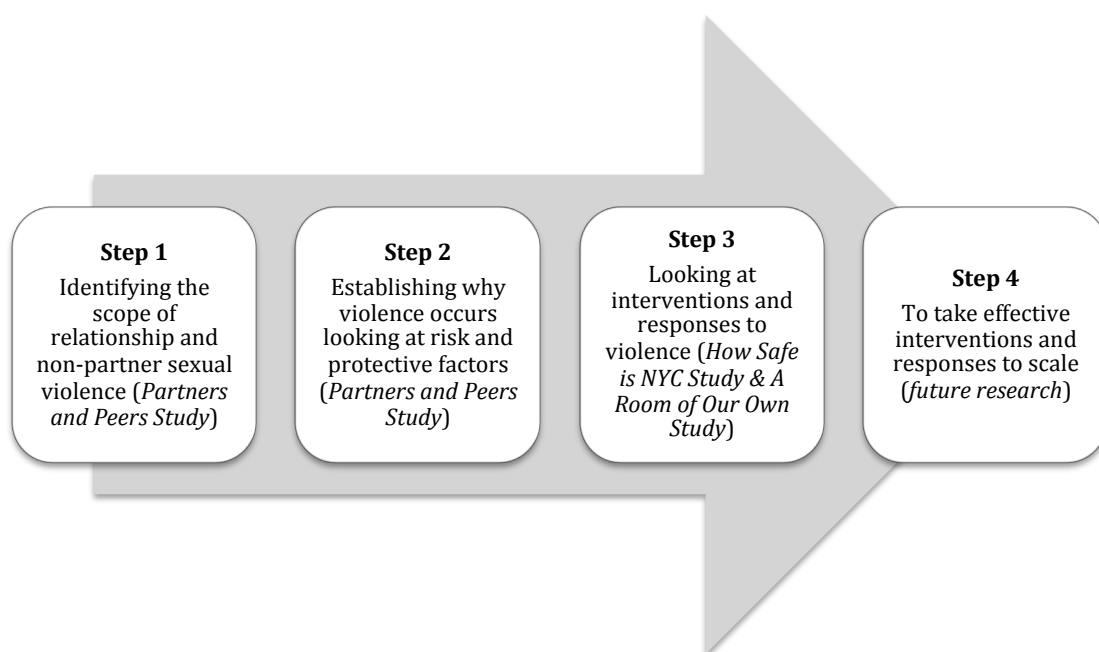
The public health model is a useful framework for addressing the potential gaps in the field and the position of adolescents as being 'between' fields of inquiry. The public health model is used extensively in both adult and child fields and frames research in a series of steps that can be used to understand better the nature of the problem *and* provide effective responses – two key issues in understanding relationship violence and non-partner sexual violence among adolescents and young adults.

The overall conceptual model guiding the design, interpretation and recommendations coming out of the findings from the body of work is the public health approach. This approach is used widely in the violence prevention field and as illustrated by the World Health Organization, consists of four steps:

- To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
- To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.

- To find out what works to prevent violence by designing, implementing and evaluating interventions.
- To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated (WHO, 2014).

Figure 1: The Public Health Model Framework for the PhD Body of Work



This body of work contributes specifically to steps one and two—understanding the scope of the problem and identifying the causes and consequences—of the public health approach. Specific recommendations are made through the body of work to use the findings to design and improve interventions for young people and young adults in NYC. In addition, a new theoretical models were developed through this body of work: a primary prevention model that takes into account the socio-ecological framework as well as thinking about interventions (presented in publication 2..

3.3 A Critical Review of Measures Used in the Body of Work

Three survey instruments were developed, one for each study, to achieve the objectives of this body of work. Each instrument is presented in full in the appendix of the corresponding publication. The instruments used in the ‘Room of Our Own’

and the ‘How SAFE is NYC’ studies were researcher-developed and do not include any validated scales due to the unique and very specific nature of the questions asked.

Since the ‘Partners and Peers’ study was focused on the prevalence, nature and impact of adolescent relationship violence and non-partner sexual violence, several validated instruments to measure these facets were included in the overall study survey. The specific measures used in this survey are presented in Table 5 alongside information on the reliability of the measure and how it was used as well as any details on recoding conducted to enable further analyses

Appendix 2 highlights the new scales that were developed in the body of work, specifically for the publications exploring adolescent communication and help-giving behaviours. For adolescent communication, subscales were developed for verbal reasoning, conflict avoidance and escalating strategies. Verbal reasoning and temporary conflict avoidance, originally a single sub measure of the CADRI, were treated as separate constructs because evidence suggests that they have very distinct impacts on violence in relationships (Messinger et al., 2011). This table also includes Cronbach’s alpha measures of reliability as well as ratings (yes/no) using Messick’s Unified Theory of Construct Validity (1989) with the following questions:

- Consequential: What are the potential risks if the scores are, in actuality, invalid or inappropriately interpreted? Is the test still worthwhile, given the risks?
- Content: Do test items appear to be measuring the construct of interest?
- Substantive: Is the theoretical foundation underlying the construct of interest sound?
- Structural: Do the interrelationships of dimensions measured by the test correlate with the construct of interest and test scores?
- External: Does the test have convergent, discriminant, and predictive qualities?

- Generalizability: Does the test generalize across different groups, settings and tasks?

The scales developed and used in the adolescent communication publication have more positive ratings on the construct validity questions due to the scale being used in a previous publication (Messinger et al., 2011) and the replication of findings across three different samples (young adult clinic sample, adolescent clinic sample and adolescent school sample). Similarly, the help-giving scales have more limited construct validity due to the lack of replicability across different samples and the lack of clarity in terms of the underlying constructs and theoretical foundations of help-giving specifically for adolescents on relationship violence.

3.4 Critical Review of Statistical Methods Conducted in the Body of Work

Analyses were conducted in order to achieve the objectives set out for the body of work – namely, to explore the prevalence, nature and impact of adolescent relationship violence and non-partner sexual violence. For each of the studies, the literature was first reviewed to understand the theories and potential hypotheses that could be tested connected to the evidence base. Detailed data analysis plans were then created to explore and test hypotheses of specific relationships. Univariate and descriptive statistics were always performed first to help inform later multivariate analyses. Appendix 4 highlights all of the data analyses conducted as well as the purpose of the analysis and reflections on the statistical test or model chosen.

Analyses in the body of work include univariate analyses, t-tests, chi-square, ANOVA, logistic regression, and multiple variable regression. For regression analyses, a model building strategy was utilised which included variables based on theoretical constructs and grounded in previous research. Several of the included papers showcase a high number of statistical comparisons made to answer the research questions. Conducting a multitude of comparisons can increase the Type 1 error rate (believing there is a genuine effect when there is not). This can be especially problematic when there are small sample sizes and is a noted limitation in the ‘Partners and Peers’ analyses.

Appropriately handling missing data is key to ensuring robust and rigorous statistical analyses. Appendix 5 gives a summary overview of missing data for key analyses,

the pattern of missingness—that is, the manner in which data are missing from the sample—and how the missing data was handled. For analyses related to adolescent communication, pairwise deletion of cases was conducted for bivariate analyses whereas multiple imputation (the process of replacing missing data with substituted values) was required for multivariate analyses. For the adolescent help-giving and help-seeking analyses, given that little data was missing, pairwise deletion of cases was conducted.

3.5 Validity and Generalizability

There are several limitations that should be noted with the included studies that impact on validity and generalizability of findings. A study is valid if its questions actually measure what they claim to, and if there are no logical errors or biases in drawing conclusions from the data. ‘Internal validity’ is a term that refers to whether variables other than those being studied may have in some way affected the outcome or variable under study. ‘External validity’ is concerned with all the situational aspects that could potentially limit generalizability (such as variables related to the investigator, timing, location, etc). Like external validity, ‘construct validity’ is related to generalising. However, where external validity involves generalising from the study context to other people, places or times, construct validity involves generalising from the measures or questions to the concept of the measures and questions. Several threats to validity were examined across the studies and attempts were made to limit the biases and threats to validity.

One of the limitations and threats to validity that is present in all the studies is that because non-random sampling methodologies were used, some participants had no chance of being sampled, which limits the extent to which these samples represent the population of study. Therefore, there are significant limitations on the generalizability of findings past the specific samples included in these studies. Due to the methodology of the studies, it is uncertain if other factors have played a role in why certain schools or individuals participated in the studies. For example, in the Partners and Peers study, it is not known if the schools that chose to participate were different from schools that did not choose to participate (they have higher or lower rates of violence, more committed staff, etc.). Similarly, due to the cross-sectional

nature of the studies, the temporal relationship between variables could not be tested. Wherever possible, this limitation was addressed by trying to ensure robust sampling designs once the sampling frame was established to further limit any selection bias and to indicate time ('in the last year', 'ever', etc.) in survey questions. Despite these limitations, which are common in studies on violence prevention, the studies included in this body of work provide tremendous insight into the violence experiences of and available services for young people in NYC.

The Partners and Peers Study has a significant amount of missing data (1,312 surveys from a total of 1,454). This level of missing data can reduce the representativeness of the sample and as a result, distort inferences about the population. Missing data can occur for a number of reasons including not responding to particular questions, inability to answer owing to a lack of knowledge, inability to remember accurately or reluctance to respond due to embarrassment or fear of interventions (UN, 2014). Despite the level of missing data, strategies for reducing the amount of missing data was incorporated into the design of the questionnaire and interviewer training and data collection (including use of ACASI). Several surveys were invalidated due to being seen as a joke where inappropriate responses were included in open-ended questions. This is not unique to this study and has been documented elsewhere including in the recent UBS Optimus national prevalence studies on sexual victimisation among adolescents (Averdijk et al., 2011).

Another limitation that is present in the help-seeking and help-giving findings was the translation error in Spanish for one of the help-seeking questions on the survey. This presents a limitation in that the analyses explored nativity and help-seeking and students who preferred to take the survey in Spanish may be underrepresented in the findings and/or significantly different from participants who preferred to answer the survey in English on these key variables of interest. Further analyses are needed to determine the impact of the exclusion of these participants (due to the translation error) on the survey findings.

Another threat to validity is known as the ‘Hawthorne Effect’, which postulates that the expectations or actions of the investigator may contaminate the outcomes of the study. Does administering a survey within school settings have an impact on respondents’ responses to relationship violence questions? What about administering a survey to survivors within a counselling setting? Does this impact survivors’ answers on the satisfaction they have with services? Practices to limit these potential biases were incorporated for example, by not having teachers or counsellors administer the surveys, by assuring participants about their anonymity, and by ensuring rigorous academic and policymaker peer review of protocols, questionnaires and all study materials.

In addition, history and maturation bias may also be present in these studies particularly in the ‘Partners and Peers’ and the ‘Room of Our Own’ studies. For example, it is possible that the survivors surveyed in community-based and counselling programmes differ in maturation of the passage of time since their assault than survivors who only access hospital or law enforcement services and this may then effect their reflections on satisfaction with those services. The direction of this effect is unknown. Another form of maturation bias can be found in the ‘Room of Our Own’ study, which asked survivors of all ages to reflect on their satisfaction with services. In this study, older survivors may have been interacting with services several years if not decades previously. These responses will not likely take into account any new provisions in services (such as specialized units) for sexual assault survivors.

Similarly, one limitation that can be difficult to control for when conducting violence prevention research in schools is that schools in the sample may have had differing exposures to prevention programmes or awareness raising activities in the past. This, in turn, may make students more aware of different types of behaviours, which may impact on their answers on the surveys. Similarly, schools that are interested in addressing violence as an issue are also more likely to want to undertake research in this area. To limit this potential bias, detailed information about previous activities in the schools related to this topic was collected and all schools had equally minimal

exposure to violence prevention and previous awareness raising activities. A question was also included in the survey to ask about participants' own exposure to these issues through various avenues (media, schools, community programmes, etc.) Similarly, participants own recall bias can also be a limitation in the study. Adolescents are often 'closer' to the experiences of childhood and thus may present higher prevalence estimates than adult samples.

Construct validity is a particular concern in the violence prevention research field. While a lot of work has been done to validate instruments, there is still considerable cultural norm and contextual influence on the meanings of violence and abuse in different settings and with different populations. Qualitative research might assist in a more finely grained understanding of constructs of adolescent relationship violence and non-partner sexual violence and how adolescents define their own approaches to help-giving and help-seeking. Qualitative approaches may also allow more scope for survivor responses as compared to quantitative surveys. Another limitation is that all behaviours (help-seeking, violence use or receipt, etc.) are self-reported, and it was not possible to cross-validate responses or match responses with those providing services.

There is also, compared to other fields, a fairly weak, diverse and divergent theoretical basis for understanding behaviour in relation to adolescent relationship violence and non-partner sexual violence, all of which impacts on construct validity. Where possible, validated instruments have been used and constructs linked to theory but much of the work presented is exploratory in nature with the associated validity limitations.

4. Critical Review of Findings in the Body of Work

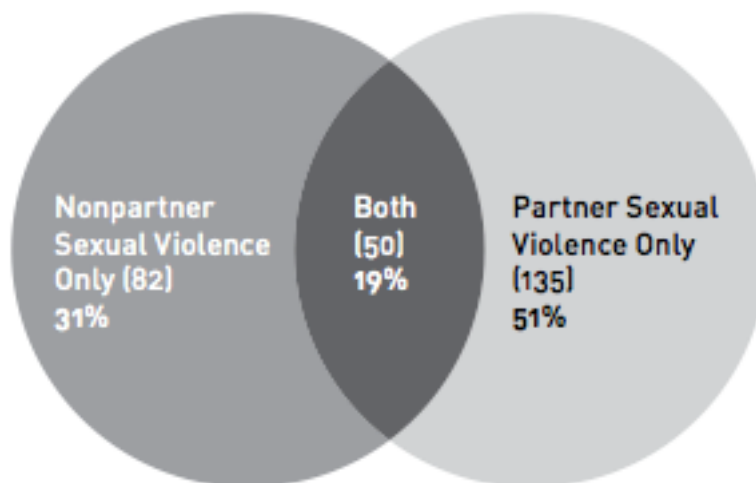
Detailed findings from all studies are included in the corresponding publications.

This chapter, due to space constraints, only contains a summary of the key findings related to the objectives of the body of work. Sample descriptions and key demographic variables are not presented here but can be found across multiple publications in the body of work.

4.1 Prevalence of Adolescent Relationship Violence and Non-partner Sexual Violence

The Partners and Peers study with high school students found that more than one in six students reported having experienced sexual violence at some point in their lives (either non-partner or partner sexual violence). Of all respondents, 6 % ($n=81$) reported one or more occurrences of experiencing child sexual abuse in their lifetime and 10% ($n=98$) reported a history of partner sexual violence. Nearly one in five young people who have experienced sexual violence experienced both partner and non-partner sexual violence.

Figure 1: Experiences of Non-partner and Partner Sexual Violence among High School Students from the Partners and Peers Study ($n = 1,312$)*

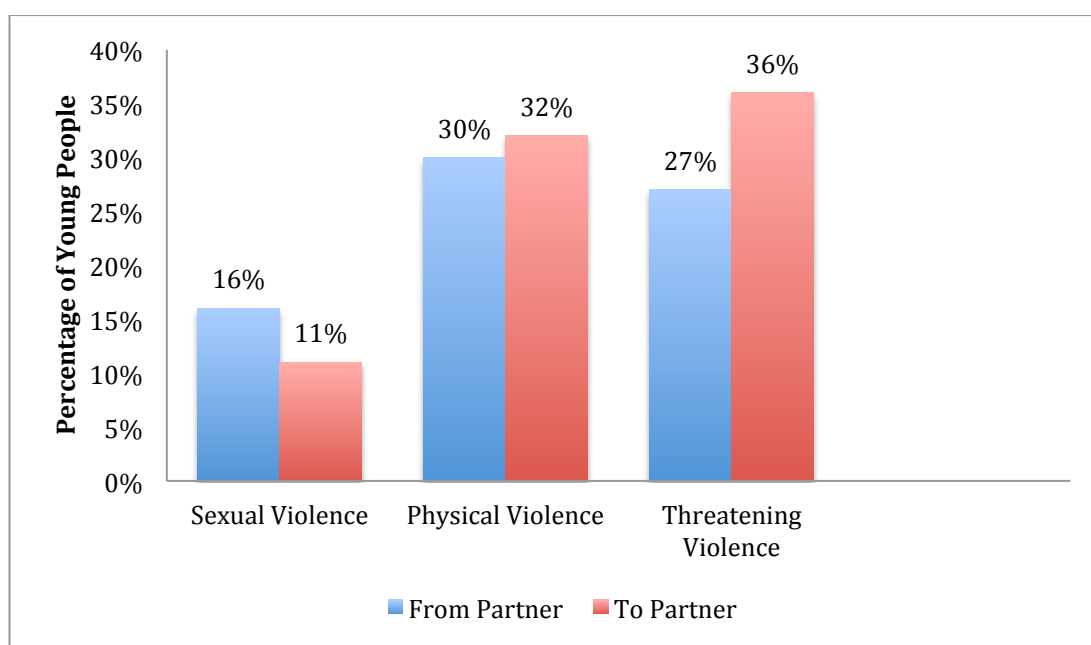


*Partner sexual violence questions from the Dating Violence Inventory (DVI), which measures violence in any dating relationship (current or past) and the Family Abuse Scale, which measures non-partner sexual violence.

With regard to receipt of adolescent relationship violence, 38 % ($n=384$) of respondents reported experiencing physical and/or sexual relationship violence at some point in their lifetime, with 36 % ($n=363$) reporting experiencing physical relationship violence and 10 % ($n=98$) sexual relationship violence. This is similar to other prevalence studies of relationship violence among adolescents (CDC, 2011; Silverman et al., 2011).

Figure 2 highlights the self-reported behaviours of students in both using and receiving violence in their current relationship. Over a third of young people ($n=318$) reported using threatening and controlling behaviours towards their partner during a conflict or argument and nearly a third report ($n=283$) using physically violent behaviours towards their partner. A smaller percentage (11%, $n = 97$) reported using sexual violence against their partner during a conflict or argument in the past year.

Figure 3: Self-reported Adolescent Relationship Violence Behaviours*

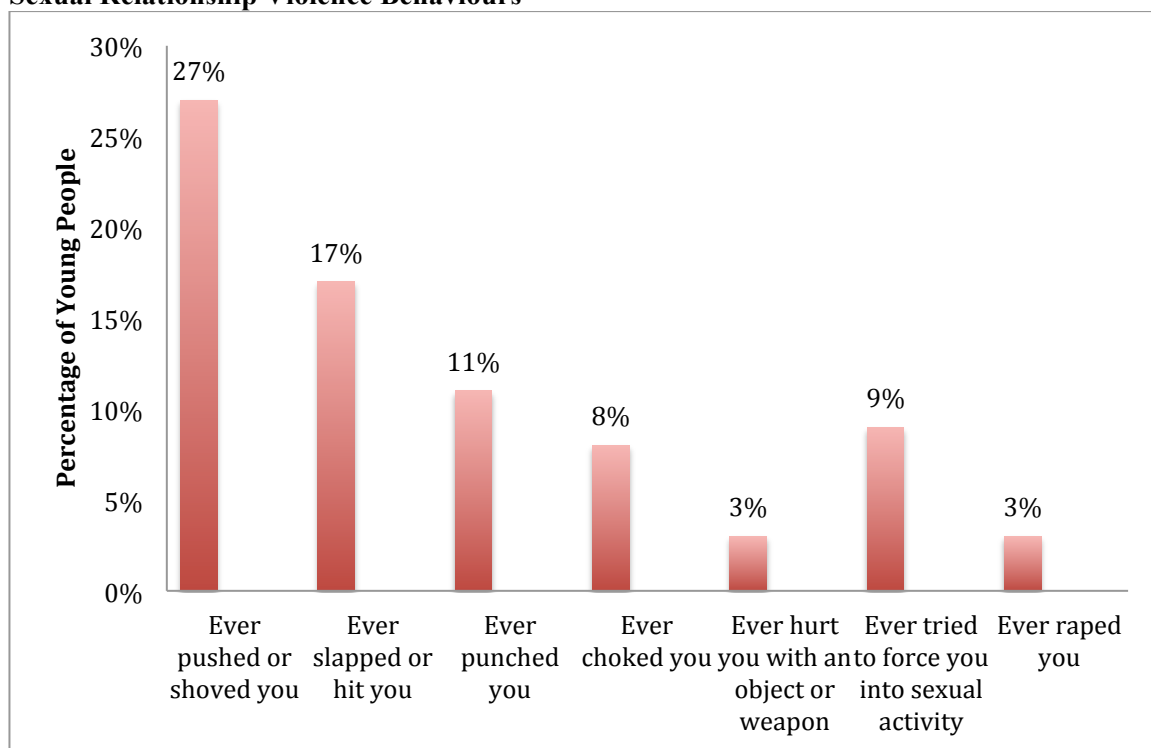


* Denominator based on $n=883$ young people who reported having a partner in the 1st year. The scales are from the Conflict in Adolescent Dating Relationship Inventory (CADRI). The sexual violence scale is based on three questions and excludes forced kissing.

If we look more in-depth at the behaviours that underlie lifetime experiences of physical and sexual violence, as presented in figure 3, we see that pushing/shoving,

slapping and hitting and punching were the most prevalent. More severely violent behaviours such as choking and hurting with an object or weapon were less frequent among this sample. Despite being less frequent, these potentially lethal behaviours still occur at alarming rates.

Figure 4: Percentage of Young People who Report Ever Experiencing Physical or Sexual Relationship Violence Behaviours*



*Denominator based on $n = 1,017$ young people who had started dating or had any romantic and/or sexual relationship. The questions are from the Dating Violence Inventory (DVI).

For physical violence within their current relationship, 12% ($n = 106$) of respondents reported that their partner slapped them or pulled their hair and 19% ($n = 168$) reported their partner pushed, shoved or shook them during a conflict or argument during the last year. Similarly, 12% ($n = 106$) reported their partner kicked, hit or punched them and 16% ($n = 141$) reported their partner threw something at them during a conflict or argument in the last year.

For sexual violence within their current relationship, 10% ($n = 83$) reported their partner touch them sexually when they didn't want their partner to touch them during

a conflict or argument and 7% ($n = 58$) reported their partner forced them to have sex when they didn't want during a conflict or argument in the last year.

Additional data on the prevalence of controlling behaviours disaggregated by sex as well as the prevalence of youth violence behaviours are presented in several publications in the body of work.

4.2 Nature of Adolescent Relationship Violence and Non-partner Sexual Violence

In terms of adolescent relationship violence, the findings from this body of work suggest that the nature of adolescent relationships may be very different from what we know about adult relationships, especially in relation to communication and typologies of violence. The findings also suggest that for both relationship violence and non-partner sexual violence, adolescents may experience and use multiple forms of violence and that when they do experience violence, adolescents rely on friends first for help and may initially seek mostly informal sources of support.

4.2.1 Adolescent Communication

A key cornerstone of all relationships is communication, yet little is known about what communication strategies young people use within conflict and argument situations in their relationships. The analyses published in this body of work (publication 3) are among the first to explore with a high-school population whether various communication strategies are associated with relationship violence. The literature review in this publication highlights that the existing research shows that verbal reasoning communication strategies (e.g. talking to partner to calm down situation, etc.) can help defuse conflict and the potential for violence, whereas escalating communication strategies which includes verbal aggression and controlling tactics has the potential to escalate conflicts to violence. Other communication strategies include conflict avoidance. The literature also highlights that developmentally, adolescent communication may be very different from young adult communication patterns (see publication 3).

This body of work tested the role of communication in adolescent relationship violence among females by examining differences between the 15- to 19-year-old female adolescents (both a clinic and a high-school based sample) and 20- to 24-year-old female young adults in from a clinic sample (Messinger et al., 2011).

Findings indicate that in all samples, all communication strategies were used and received significantly more frequently (t test, $p < .05$) in violent relationships than nonviolent relationships. Importantly, contrary to what was hypothesised, no significant differences were found between the adolescent and young adult clinic samples in reported mean frequencies of communication strategies and violence. This suggests that aging may affect the motivations behind and perceptions of communication strategies more so than the frequencies with which those strategies are employed.

Regarding the key predictors in these multivariate models, escalating strategies were positively associated with physical violence used and received in all three samples (adolescent clinic, adolescent high-school and young adult clinic), a finding replicated in other research on adolescents (Halpern et al., 2001). These findings show that a one-unit increase in the amount of escalating strategies by either partner was associated with an increase in violence used by 13% to 20% and violence received by 20% to 23%.

Some differences among samples emerged in relation to communication strategies. For the young adult clinic patients, avoidance used and received was associated with an increase in violence used (18%-20% per unit increase of avoidance), and reasoning used and received were associated with a decrease in violence received (9% per unit increase of reasoning). Conversely, for the adolescent patients, every unit increase of reasoning received was associated with a 7% decrease in violence used. This particular adolescent clinic sample result on reasoning—in only one sample and with a weak effect size—was the only to differentiate the two adolescent samples. Beyond this, the remaining results of the adolescent clinic sample were replicated with the adolescent school sample, with only escalating strategies (in all

models) predicting violence as presented in the published article included in this body of work.

The results suggest that, once one reaches young adulthood, reasoning by either partner is not associated with violence by females but is predictive of a decrease in violence by their male partners. Future research should explore the qualitative use and interpretation of reasoning in relationships, with a strong focus on gender differences. As indicated by the two clinic samples, by young adulthood, temporary avoidance used and received may become a significant trigger to violence for women, which contradicts one of the few articles on this topic (Furman & Wehner, 1997).

Overall, these analyses show that certain communication strategies may be unique to adolescence and that data from young adults may not be a good proxy of what is happening in adolescent relationships.

4.2.24 Nature of Help-Giving and Help-Seeking Behaviours

A series of help-seeking and help-giving questions were asked in the 'Partners and Peers' study. Findings show that of youth who had experienced relationship violence (physical and/or sexual), 61% ($n=78$) told someone about that violence. Among those who experienced relationship violence in their lifetime, male victims were significantly less likely than female victims to seek help (odds ratio (OR)=0.27, 95% confidence interval (CI) 0.13–0.60). There were no other significant differences, besides gender, that predicted help-seeking behaviour by the respondent. This is consistent with other research findings that males are less likely to seek help than females (Ansara & Hindin, 2010). This may be due in part to certain masculinity norms that inhibit help-seeking and reporting victimization in general or the lack of victim services designed specifically for men (Courtenay, 2003). While this study asked measured gender differences, qualitative research would be helpful for understanding the gendered norms and contexts around help-seeking for males.

For those relationship violence victims who had disclosed, they were more likely to choose their friends for informal support echoing previous research findings (Ashley & Foshee, 2005; Ocampo et al., 2007; Weisz et al., 2007). Of those that disclosed their experiences of relationship violence, a small percentage (12%, $n=9$) had only told an adult about the violence, nearly half (46%, $n=36$) had only ever told a friend but no adult, and 42% ($n=33$) had told both an adult and a friend. Additionally, the first person initially disclosed to was a friend for 72% of adolescents who had experienced relationship violence.

Over a fifth (22%) of the students reported that they had a friend currently in a violent relationship ($n=272$). In terms of help-giving behaviours, adolescents responded to their friends' situation in a variety of ways including talking with the friend about the violence (79%, $n = 209$), giving advice (82%, $n =216$), telling the friend to leave the partner (80%, $n=209$), talking directly to the friend's partner about the violence (52%, $n=137$), telling the friend to talk to an adult about the violence (50%, $n=134$), and talking to an adult about the friend's experience of violence (47%, $n=124$). Among the least commonly employed tactics were calling a hotline on behalf of the friend (14%, $n=36$) and advising the friend to call a hotline (19%, $n=49$).

Very few adolescents gave only one form of help to their friends who were in a violent relationship, with the majority of adolescents (64%, $n=169$) providing all three types of help—talking to their friends, suggesting options to their friends, and taking action on behalf of or with their friends.

Help-givers' own histories of relationship violence and child sexual abuse were not significantly associated with any type of help-giving behaviour they provided to their friends. However, findings show that males were less likely than females to give all forms of help to their friends. After controlling for ethnicity and nativity, males were still significantly less likely to give all forms of help to their friends. Foreign-born adolescents were significantly less likely to talk to their friends and suggest options to their friends, but there was no significant difference regarding taking action on

behalf of, or together with, friends experiencing relationship violence. After adjusting for gender and nativity, Latinos were nearly twice as likely as non-Latinos (OR (95% CI)=1.91 (1.06, 3.46)) to take action to help to their friends, but no significant differences were found between these two groups regarding the other help-giving behaviours.

Overall the findings suggest that adolescents are often first responders to their friends' disclosures of relationship violence and that adolescents give various forms of support and help.

4.3 Impact of Adolescent Relationship Violence and Non-partner Sexual Violence on Young People's Health and Well-being

Findings from the 'Partners and Peers' study highlight the significant impact of relationship violence and non-partner sexual violence on young people's self-reported health and well-being. Several open-ended questions were also included in the study to gather young people's own perceptions of the impact of violence on their lives.

Multivariate analyses demonstrated that recent and prior experiences of relationship violence were associated with several health outcomes. Young people who reported receiving recent physical (AORs:1.5-1.7) and/or recent sexual (AORs:1.8-1.9) relationship violence as compared to those who had not, were significantly more likely to report high levels of physical and emotional discomfort (i.e., greater number of physical and emotional symptoms in the past month and year using the CHIP-AE scale). Young people who reported recent receipt of sexual relationship violence were 2.3 times more likely to report fair to poor health status. Similarly, those who reported ever experiencing physical (AORs: 1.7-2.0) and/or sexual (AORs: 1.8-2.6) relationship violence as compared to no lifetime relationship violence experiences reported both higher physical and emotional discomfort.

These findings highlight the significant impact of relationship violence on adolescents and echo findings from previous studies showing the short- and long-term consequences on health and well-being of experiencing violence.

4.4 Mapping Acute Care Services for Sexual Violence in NYC

New York City has more Emergency Departments than other city in the United States – 63 at the time of the ‘How SAFE is NYC’ study. This study mapped the specific services provided for patients reporting a sexual assault across five domains: medical care, forensic evidence collection, advocacy/information-giving and follow-up care and quality assurance. The key finding highlighted that which ED a patient presented at determined the level of services and quality of care provided (as measured against State and national protocols of best care service provision for sexual assault patients) and that specialised programmes are scattered across the city in no systematic way. The Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Response Team (SART) programmes surveyed offered the most comprehensive care to sexual assault patients in NYC’s emergency departments. These programmes all utilise specially trained doctors and nurses to conduct rape exams, were more likely to have specialised equipment, and reported providing more information and follow-care for patients than non-SAFE/SART EDs.

Findings also highlighted that all public (city-run) hospitals surveyed provided comprehensive care for sexual assault patients in their EDs – half of these hospitals were SAFE Centres of Excellence at the time of the study. This finding is not surprising as the public hospitals in NYC have been pioneers, alongside a few private hospital EDs, in providing specialised care for sexual assault patients in NYC.

Emergency contraception and HIV post-exposure prophylaxis (PEP) is provided in nearly all EDs surveyed, regardless of whether they have a SAFE programme.

Finally, there was mixed responses by ED Directors as to clinical decision-making standards used to determine whether an adult or child protocol is used. Specialised SAFE programmes were more likely to use clinical judgement on a case-by-case

basis depending on the age/maturity of the patient and the specific details surrounding the case (chronic vs. acute assault), whereas EDs without a specialised programme were more likely to use a strict age cut-off (usually 18 years of age) for using the adult protocol. This finding suggests that adolescents, who through this body of work have been identified as particularly at risk for both relationship and non-partner sexual violence, may not be getting the best provision of care in acute hospital care settings.

4.5 Survivors' Perspectives on their Level of Satisfaction with Services in NYC

The 'Room of Our Own' study examined survivors' satisfaction with services (hospital, rape crisis, police and district attorney's offices) they accessed in NYC after experiencing a sexual assault. Overall, 79 survivors responded to the survey, though while a small number is still important for understanding survivors' perspectives for service delivery improvements. This study included respondents of all ages but for nearly 60% of the sample, the sexual assault occurred and services were accessed when they were between the ages of 18-25.

Survivors of sexual violence shared a range of experiences with service providers but a key finding indicates that overall they were most satisfied with the care they received at rape crisis programmes. Many respondents indicated that they did not receive adequate care or follow-up from the hospital but those who attended a hospital with a Sexual Assault Forensic Examiner (SAFE) programme were more satisfied with the care they received than those who went to a hospital without a specialised programme. Additionally, the presence of a volunteer victim advocate (most often associated with a rape crisis programme) at the hospital had a statistically significant impact on the survivors' satisfaction with the care they received at the hospital.

Overall, the respondents were either 'satisfied' or 'very satisfied' with their treatment by both uniformed officers (78%, $n=25$) and non-uniformed officers (57%, $n=18$). Twenty-five survivors gave recommendations for improving police services for other survivors including more training for police officers, providing referrals to other

services, to treat sexual assault as a serious crime, to ensure more privacy for survivors when talking about the assault and to have more female officers handling sexual assault cases.

A much smaller percentage of the sample (34%, $n = 22$) went to the District Attorney's office after experiencing sexual violence. This smaller percentage is due to the fact that navigating the criminal justice process often occurs after a survivor has already accessed other services (such as hospital and police). It is very rare that the criminal justice system is the first point of contact after a sexual assault. Respondents were asked what prevents survivors from seeking criminal justice services with four main themes emerging from their responses: the lack of information about the criminal justice process, that the perpetrator was never caught or charges were not filed against that person and difficulties in contacting the District Attorney's office.

While the findings from the 'Partners and Peers' study highlights that few survivors seek formal care, for those that do the quality of the care they receive and how they are treated is important for their recovery from the trauma of sexual violence. What is clear from the 'Room of Our Own' study and how it adds to the body of work is that while many survivors are receiving adequate care in a respectful manner, many are not and are in fact being retraumatized by the very services set up to help them. There is also clearly a gap in provision of services and the quality of those services as perceived by young people.

5. Recommendations for Response and Prevention

The high prevalence of relationship violence and non-partner sexual violence among young people and young adults requires a comprehensive intervention and prevention response. A summary of the recommendations arising from the body of work are presented below:

1. Schools and programmes that work with young people should include a focus on primary prevention programming.

Primary prevention focuses on examining and addressing the root causes of violence such that we can end violence before it ever occurs and prevent the negative health and well-being impacts of violence. Prevention programmes should take into account the nature of relationship violence and non-partner sexual violence and develop specialised programmes for young people (recognising their particular relationships and communication will be different than adult populations).

2. Teens should have access to youth-friendly referral information, training and support.

Given that teens disclose incidents of sexual and dating violence to friends first, providing them with referral information is key to helping them support each other. One such resource that I developed for the ‘Partners and Peers’ study is the NYC Teen Health Map, a subway map on one side and a service guide for youth on the other, which folds into a discreet card to be tucked into a wallet.

3. Professionals should be trained on how to provide best care to young people and young adults who have experienced relationship violence or non-partner sexual violence and be provided with training on properly handle disclosures and further referring young people to services.

Since many youth who have experienced relationship violence or non-partner sexual violence tell someone about that violence, it is imperative that all those who work

with young people are trained in how to properly handle disclosures and how to refer to further services. Proper responses to disclosures of violence require sensitivity and respect be given to the survivor. This training should be inclusive of several audiences: youth workers including afterschool programme staff; school staff including teachers, guidance counsellors, nurses, security guards, and janitors among others; and health professionals. Furthermore, all sectors of formal services (hospital, rape crisis programmes, police and criminal justice) should be provided with training on ensuring the best care to young people and young adults who have experienced violence.

6. Contributions of the Body of Work

Three of the six submitted publications have already been ranked internally as part of the Moray House School of Education's 2013 REF submission and they have all been recognised as internationally excellent in terms of originality, significance and rigour.

This body of work has had, and continues to have significant implications for practice in NYC. After completing the 'How SAFE is NYC' study, which highlighted the unequal care provided across New York City for acute violence patients, New York State laws for ambulance destination designation were changed. This came after collaboration with the Regional Emergency Medical Advisory Committee of the Regional Emergency Medical Services Council of New York City (REMAC/REMSCO), Fire Department of New York (FDNY), and the Mayor's Office. Starting from 8 June 2008 sexual assault victims now have the choice of being transported to hospitals with specialised care and counselling (SAFE programmes). In addition at the press conference for the research, the NYC mayor's office committed to ensuring a geographic spread of SAFE services in NYC and in all public hospitals.

This research also led to the development of the Health and Forensic Services Programme in collaboration with the New York Academy of Medicine and the Greater New York Hospital Association, which applies the public-private partnership approach to acute health care services for sexual assault patients. This public-private partnership approach involves cooperation among public and private sectors seeking to solve a shared problem and address a community need through a joint venture - ultimately benefiting the broader community. The SAFE NYC Initiative calls for universal access to patient-centred sexual assault acute health services for all sexual assault survivors in NYC.

The 'Partners and Peers' study led to the development of a resource for young people called the New York City Teen Health Map. Originally, an initiative to provide resources to the young people taking the school-based survey, I took the lead in

developing this resource for wider access. This involved conducting an additional qualitative study with young people to develop and evaluate the resource. The New York City Teen Health Map is a foldable pocket-sized resource with a subway map on one side and a comprehensive list of services for young people experiencing violence on the reverse side. Upon publication of the findings from the study, the New York City Department of Education ordered 40,000 New York City Teen Health Maps to distribute to young people throughout New York City schools. The school-based study findings also directly led the NYC Chancellor to change the disciplinary regulations in all New York City high schools in relation to adolescent relationship violence.

6.1 My Contribution to Research and Published Body of Work

It is very uncommon to have single authored papers in the field of violence research, which is often characterised by primary qualitative and quantitative research. As specified in the PhD by Publications guidelines, I have made a major contribution to all of the work that has been produced by more than one author. All of the co-authors have agreed to the write-up of my contribution as highlighted below:

Role in Research:

1. Partners and Peers Study:

I was the co-PI for the study, which involved primary data collection at four high schools (sample size 1,312). I led the study at three out of the four high schools with the Columbia University Centre for Youth Violence Prevention leading the study at the remaining high school. Two of the schools utilised paper and pencil surveys and two schools used an electronic survey instrument. I made a major contribution to survey development including leading on the non-partner sexual abuse questions and the help-giving and help-seeking questions; contributed significantly to the ethics review submission (from three institutions—led the Alliance ethics board and contributed to the Columbia University's ethics Board and the NYC Department of Education); contributed to overseeing/piloting the Automated Computer Assisted Self Interviewing (ACASI) programming for electronic versions of the survey; led the translation and back-translation into Spanish and Chinese of the surveys,

developed parent letters and consent forms; led the piloting of the survey with young people in three of the high schools; worked with the schools to obtain parental passive consent and youth assent to participate in the study; made a major contribution towards collecting the data in three of the four schools; managed the data entry for all the paper surveys; cleaned the data; contributed to analysing the data; lead the report writing and presented data at a press conference and follow-up meetings with the Department of Education on the findings of the study.

2. How SAFE is NYC Study:

I was PI of the study ‘How Safe is NYC’ which comprehensively mapped service provision for sexual assault survivors in 39 emergency departments (EDs) across NYC. I lead in development of the study coordinating three advisory groups of professionals (researchers, police and assistant district attorneys, and health professionals) to develop and pilot the survey instrument. I was responsible for data collection, data entry, data cleaning and analysis and report writing and working with the media, local government and state officials to disseminate and translate findings into local procedures and state law.

3. A Room of Our Own Study:

In addition, I was the PI on a study titled *A Room of Our Own: Survivors Evaluate Services*, which was the first ever city-wide report that includes the survivor perspective in both the experiences of services and in the recommendations for service improvement. I led the development of the electronic database and layout, the piloting of the survey in different browsers, operating systems, internet service providers, etc. and the migration of the database into SPSS; obtaining ethical review board approvals; piloting, recruitment of participants, data analysis and report writing.

Role in Writing:

I have either led or made a major contribution to all of the work that has been produced by more than one author.

1. 'Partners and Peers' report: lead author and made a major contribution in writing of all chapters, tables, text boxes, graphs and appendices.
2. 'How SAFE is NYC' report: sole author.
3. 'A Room of Our Own' report: sole author.
4. Revisiting the Role of Communication in Adolescent Intimate Partner Violence. *Journal of Interpersonal Violence* – as co-PI of this study made a major contribution to the data collection of the high school sample and developing analytical frameworks, made a significant contribution to writing the literature review and discussion section.
5. Adolescent Relationship Violence: Help-Seeking and Help-Giving Behaviours among Peers. *Journal of Urban Health* – lead author, led on the conceptualisation and development of the analytical framework for the paper, made a major contributing to the writing of all sections of the article.
6. *Sexual Assault Victimization Across the Lifespan: Rates, Consequences and Interventions for Different Populations*. Victims of Crime, RC Davis, A. Lurigio & S. Herman, editors, 3rd edition. London: Sage – made a major contribution to the research on and writing of all sections of this book chapter including sexual violence across the lifespan, research, policy and practice directions and emerging topics in the field.

7. Conclusion

This coherent body of research highlights the need for practitioners, policymakers and researchers to better understand the nature of relationship violence and non-partner sexual violence among young people and young adults in New York City in order to develop evidence-informed programmes and policies for prevention and response.

This body of work consists of research to explore the ‘missing middle’ of adolescence – a group that sits at the thresholds between adult and child studies and the implications for this in research, policy and practice. This body of work clearly articulates that adults are not good proxies for adolescents and that more research is needed to understand better the context of relationships and violence within this age range. This work also shows that this age group may be missed in services because they sit between these two very different service provision groups (those that focus on adults and those that focus on children).

Results from this body of work can be used by researchers and those working with young people to further understand the predictors shaping relationship violence and non-partner sexual violence. Data from this body of work push the discourse forward on the nature and impact of relationship violence and non-partner sexual violence including communication in adolescent and young adult relationships, helping among peers and the types and nature of violent relationships. Given these findings, future empirical and policy-oriented work should continue to explore how these issues are affected by life transitions between adolescence and young adulthood.

This body of work also provides ample evidence for designing and improving services for survivors of violence in NYC and highlights the particular considerations that should be given to best caring for young people and young adults who use and receive violence in their relationships and for those that experience non-partner sexual violence.

References Cited in the Critical Review

Adverdijk, M., Muller-Johnson, K. and Eisner, M. *Sexual victimization of children and adolescents in Switzerland*. Zurich: UBS Optimus Foundation, 2011.

Anderson, K. L. (2005). Theorizing gender in intimate partner violence research. *Sex Roles*, 52(11-12), 853-865.

Ansara, D. L., and Hindin, M. J. (2010). Exploring gender differences in the patterns of intimate partner violence in Canada: A latent class approach. *Journal of Epidemiology & Community Health*, 64, 849-854.

Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin*, 126(5), 651-680.

Ashley, O.S., and Foshee, V.A. (2005). Adolescent help-seeking for dating violence: prevalence, sociodemographic correlates, and sources of help. *Journal of Adolescent Health*. 36: 25–31.

Azikiwe, N., Wright, J., Cheng, T. and D'Angelo, L.J. (2005). Management of rape victims (regarding STD and pregnancy prevention): Do academic emergency departments practice what they preach? *Journal of Adolescent Health*, 36, 446-448.

Breiding, M.J., Smith, S.G., Basile, K.C., Walters, M.L., Chen, J. and Merrick, M.T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization — National Intimate Partner and Sexual Violence Survey, United States, 2011. *Surveillance Summaries*, 63(SS08), 1-18.

Caetano, R., Field, C., Ramisetty-Mikler, S., & Lipsky, S. (2009). Agreement on reporting of physical, psychological, and sexual violence among White, Black, and Hispanic couples in the United States. *Journal of Interpersonal Violence*, 24(8), 1318-1337.

Campbell, R., Patterson, D., Adams, A.E., Diegel, R. and Coats, S. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being. *Journal of Forensic Nursing*, 4, 19-28.

Catalano, S. (2004). Criminal victimization, 2003. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Accessed online: <http://www.ojp.usdoj.gov/bjs/abstract/cv03.htm>.

Centers for Disease Control and Prevention (CDC). *The National Intimate Partner and Sexual Violence Survey (NISVS)*. Atlanta: CDC, 2011.

Centers for Disease Control and Prevention. (2006). Youth risk behavior surveillance: United States, 2005. *Morbidity and Mortality Weekly Report: Surveillance Summaries*, 55(5), 1-108.

Christofides, N.J., Jewkes, R.K., Webster, N., PennKekana, L., Abrahams, N. and Martin, L.J. (2005). "Other patients are really in need of medical attention"—The quality of health services for rape survivors in South Africa. *Bulletin of the World Health Organisation*, 83, 495-502.

Ciancone, A., Wilson, C., Collette, R. and Gerson, L.W. (2000). Sexual Assault Nurse Examiner Programs in the United States. *Annals of Emergency Medicine*, 35, 353-357.

Courtenay, W.H. (2003). Key determinants of the health and well-being of men and boys. *International Journal of Men's Health*. 2(1): 1–30.

Crandall, C. and Helitzer, D. (2003). *Impact evaluation of a Sexual Assault Nurse Examiner (SANE) Program* (Document No: 203276). Washington D.C.: National Institute of Justice.

Dardis, C.M., Dixon, K.J., Edwards, K.M., and Turchik, J.A. (2014). An examination of the factors related to dating violence perpetration among young men and women and associated theoretical explanations: A review of the literature. *Trauma, Violence and Abuse*, e-pub ahead of print.

Devries, K.M., Mak, J.Y.T., Garcia-Moreno, C., Petzold, M., Child, J.C., Falder, G., Lim, S., Bacchus, L.J., Engell, R.E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N. and Watts, C.H. (2013). The Global Prevalence of Intimate Partner Violence Against Women. *Science*, 340(6140), 1527-1528.

Devries, K.M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., Astbury, J., and Watts, C.H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS medicine*, 10 (5).

Dobash, R. P., & Dobash, R. E. (2004). Women's violence to men in intimate relationships: Working on a puzzle. *British journal of criminology*, 44(3), 324-349.

Dutton, D. G., & Nicholls, T. L. (2005). The gender paradigm in domestic violence research and theory: Part 1-The conflict of theory and data. *Aggression and Violent Behavior*, 10(6), 680-714.

Ellsberg, M., Heise, L., Pena, R., Agurto, S. and Winkvist. A. (2001). Researching domestic violence against women: methodological and ethical considerations. *Studies in Family Planning*, 32(1):1-16.

Fang, X., Fry, D., Ji, K., Finkelhor, D., Chen, J., Lannen, P., and Dunne, M.P. (2015). The burden of child maltreatment in China: A systematic review. *Bulletin of the World Health Organization*, 93: 176-185.

Fehler-Cabral, G. and Campbell, R. (2013). Adolescent sexual assault disclosure: The impact of peers, families, and schools. *American Journal of Community Psychology*, 52: 73-83.

Finkelhor, D., Turner, H.A., Shattuck, A., and Hamby, S.L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth. *JAMA Pediatrics*, 167(7), 614-621.

Furman, W., and Wehner, E. Adolescent romantic relationships: A developmental perspective. In S. Shulman and W. A. Collins (Eds.), *Romantic relationships in adolescence: Developmental perspectives. New directions for child development*, No. 78 (pp. 21-36). San Francisco, CA: Jossey-Bass, 1997.

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes, and women's responses*. Geneva, Switzerland: World Health Organization, 2005.

Graham-Kevan, N., & Archer, J. (2003). Intimate terrorism and common couple violence: A test of Johnson's predictions in four British samples. *Journal of Interpersonal Violence*, 18, 1247-1270.

Halpern, C. T., Oslak, S. G., Young, M. L., Martin, S. L., and Kupper, L. L. (2001). Partner violence among adolescents in opposite-sex romantic relationships: Findings from the National Longitudinal Study of Adolescent Health. *American Journal of Public Health*, 91(10), 1679-1685.

Horner, G., Thackeray, J., Scribano, P., Curran, S., Benzinger, E. (2012). Pediatric sexual assault nurse examiner care: Trace forensic evidence, ano-genital injury, and judicial outcomes. *Journal of Forensic Nursing*, 8: 105-111.

Ingemann-Hansen, O. and Charles, A.V. (2013). Forensic medical examination of adolescent and adult victims of sexual violence. *Best Practices and Research Clinical Obstetrics and Gynecology*, 27(1): 91-102.

Jansen H.A.F.M., Watts, C., Ellsberg, M., Heise, L., and Garcia-Moreno, C. (2004).

- Interviewer training in the WHO multi-country study on women's health and domestic violence. *Violence Against Women*, 10(7): 831–849.
- Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women*, 12, 1003-1018.
- Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Boston, MA: Northeastern University Press.
- Johnson, M. P., & Leone, J. M. (2005). The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence Against Women Survey. *Journal of Family Issues*, 26, 322-349.
- Kerr, E., Cottee, C., Chowdhury, R., Jawad, R. and Welch, J. (2003). The Haven: A pilot referral centre in London for cases of serious sexual assault. *BJOG: An International Journal of Obstetrics and Gynecology*, 110, 267-271.
- Kothari, A., Sibbald, S.L. and Wathen, N. (2014). Evaluation of partnerships in a transnational family violence prevention network using an integrated knowledge translation and exchange model: A mixed methods study. *Health Research Policy and Systems*, 12(25):1-11.
- Lewis, C., DiNitto, D., Nelson, T.S., Just, M.M. and Campbell-Ruggard, J. (2003). Evaluation of a rape protocol: A five-year follow-up with nurse managers. *Journal of the American Academy of Nurse Practitioners*, 15, 34-39.
- Martin, S.L., Young, S.K., Billings, D.L. and Bross, C.C. (2007). Health care-based interventions for women who have experienced sexual violence: A review of the literature. *Trauma, Violence and Abuse*, 8, 3-18.
- Messick, S. Validity. In R.L. Linn (Ed.), *Educational measurement* (3rd ed., pp. 13-103). New York: Macmillan, 1989.

Messinger, A. M., Davidson, L. L., & Rickert, V. I. (2011). IPV among adolescent reproductive health clinic patients: The role of relationship communication. *Journal of Interpersonal Violence*, 26, 1851-1867.

New York City Department of Health and Mental Hygiene, Department of Education, & National Centers for Disease Control and Prevention. (2007). New York City Youth Risk Behavior Survey. Retrieved from <http://www.nyc.gov/html/doh/html/data/youth-risk-behavior.shtml>

Ocampo, B.W., Shelley, G.A., and Jaycox, L.H. (2007). Latino teens talk about help-seeking and help-giving in relation to dating violence. *Violence Against Women*, 13(2): 172–89.

Olshen, E., McVeigh, K.H., Wunsch-Hitzig, R.A., and Rickert, V.I. (2007). Dating violence, sexual assault, and suicide attempts among urban teenagers. *Archives of Pediatric and Adolescent Medicine*, 161(6), 539-545.

Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York: Springer.

Reed, E., Raj, A., Miller, E., & Silverman, J.G. (2010). Losing the "gender" in gender-based violence: The missteps of research on dating and intimate partner violence. *Violence Against Women*, 16(3), 348-354.

Riley, A.W., Green, B., Forrest, C.B., Starfield, R., Kang, M., and Ensminger, M. (1998). A taxonomy of adolescent health: Development of the adolescent health profile types. *Medical Care*, 36, 1228-1236.

Rosenberg, K.D., DeMunter, J.K. and Liu, J. (2005). Emergency contraception in emergency departments in Oregon, 2003. *American Journal of Public Health*, 95, 1-5.

- Rubin, D. B., & Schenker, N. (2010). Imputation and multiple imputation. In N. Balakrishnan (Ed.), *Methods and applications of statistics in the life and health sciences* (pp. 425-440). New York: John Wiley.
- Samet, J.M. and Lee, N.L. (2001). Bridging the gap: Perspectives on translating epidemiologic evidence into policy. *American Journal of Epidemiology*, 154(12): Supplement.
- Simpson, L.E., & Christensen, A. (2005). Spousal agreement regarding relationship aggression on the Conflict Tactics Scale-2. *Psychological Assessment*, 17(4), 423-432.
- Silverman, JG., Raj, A., Mucci, L. and JE Hathaway. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy and suicidality. *JAMA: Journal of the American Medical Association*, 286(5): 572-579.
- Stark, E. (2010). Do violent acts equal abuse? Resolving the gender parity /asymmetry dilemma. *Sex Roles*, 62, 201–211.
- Strauss, M.A. (2011). Gender symmetry and mutuality in perpetration of clinical-level partner violence: Empirical evidence and implications for prevention and treatment. *Aggression and violent behaviour*, 16(4), 279-288.
- Symons, P.Y., Groer, M.W., Kepler-Youngblood, P., and Slater, V. (1994) Prevalence and predictors of adolescent dating violence. *Journal of Child and Adolescent Psychiatry and Nursing*.7(3), 14–23.
- UN. *Guidelines for producing statistics on Violence Against Women – statistical surveys*. United Nations Department of Economic and Social Affairs, 2014.

U.S. Census Bureau. Census of population and housing. Washington, D.C.: Government Printing Office. U.S. Census Bureau, 2012.

Weisz, A.N., Tolman, R.M., Callahan, M.R., Saunders, D.G., and Black, B.M. (2007). Informal helpers' responses when adolescents tell them about dating violence or romantic relationship problems. *Journal of Adolescence*. 30(5): 853–68.

Wolfe, D. A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A. L. (2001). Development and validation of the Conflict in Adolescent Dating Relationships Inventory. *Psychological Assessment*, 13, 277-293.

World Health Organization Violence Prevention Alliance. ‘The Public Health Approach.’ Access on October 12, 2014 at:
http://www.who.int/violenceprevention/approach/public_health/en/

World Health Organization (WHO), London School of Hygiene and Tropical Medicine (LSHTM) and the South African Medical Research Council (MRC). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization: Geneva, 2013.

Zweig, J.M., Yahner, J., Dank, M., and Lachman, P. (2014). Can Johnson's Typology of Adult Partner Violence apply to teen dating violence? *Journal of Marriage and Family*, 76(4), 808-825.

Publications in the Body of Work

1. O'Sullivan, C. and Fry D. (2007). *Sexual Assault Victimization Across the Lifespan: Rates, Consequences and Interventions for Different Populations*. Victims of Crime, RC Davis, A. Lurigio & S. Herman, editors, 3rd edition. London: Sage.
2. Fry, D.A., Davidson, L.L., Rickert, V.I. and H. Lessel (2008). *Partners and Peers: Sexual and Dating Violence Among NYC Youth*. A Research Report by the NYC Alliance against Sexual Assault in Conjunction with the Columbia University Centre for Youth Violence Prevention. New York City Alliance Against Sexual Assault: New York.
3. Messinger, A.M., Rickert, V.I., Fry, D.A., Lessel, H. and Davidson, L.L. (2012). Revisiting the Role of Communication in Adolescent Intimate Partner Violence. *Journal of Interpersonal Violence*, 27(14): 2851-2866.
4. Fry, D. Messinger, A.M., Rickert, V.I., O'Connor, M.K., Palmetto, N., Lessel, H., and Davidson, L.L. (2014) Adolescent Relationship Violence: Help-Seeking and Help-Giving Behaviors among Peers. *Journal of Urban Health*, 91(2): 320-334.
5. Fry, D. (2007). *How S.A.F.E. is NYC? Sexual Assault Services in Emergency Departments*. New York City Alliance Against Sexual Assault: New York.
6. Fry, D. (2007). *A Room of Our Own: Survivors Evaluate Services*. New York City Alliance Against Sexual Assault: New York.

Appendix 1: Literature Review Components Covered within the Body of Work (with corresponding page numbers in parentheses)

Objectives	Publication 1	Publication 2	Publication 3	Publication 4	Publication 5	Publication 6
Objective 1: Prevalence	-National prevalence estimates (35) -CSA (36) -Sexual victimisation of young people (38) -SV against homeless youth (38) -Sexual victimisation in adulthood (39) -Repeat SV(40) -CSEC (42) -Child pornography (42) -Child prostitution (43) -Sex tourism and trafficking (43) -IPV marital rape (44) -Rape in prisons (45)	-SV and ARV (20) -Prevalence among young people in NYC (20) -Non-partner sexual violence (25) -ARV (33) -Intersections of violence: dating and community violence (47)	-Adolescent relationship violence (2921)	-National estimates of SV and dating violence (321)	-	-Prevalence in NYC (51) -National and global studies on non-stranger SV (8) -Male survivors of SV (39)
Objective 2: Nature & Impact	-Emotional and physical impact of CSA (37) -Revictimisation (40)	-Defining sexual and dating violence (19) -Theories of ARV (34) -SV and ARV impact on health (55-6)	-Comms strategies (2921) -Communication as predictor of violence (2922) -Developmentally specific communication (2922)	-Impact of ARV on health and wellbeing (321) -Help-giving behaviours (322)	-	-Defining SV (5) -Sexual revictimisation (7) -LGBT survivors and heterosexist systems (29)
Objective 3: Acute Care Services	-SAFE programmes (48) -Child Advocacy Centres (48)	-	-	-Help-seeking behaviours (321)	-Defining SAFE/SART (16) -Evolution of	-Hospital care for survivors in NYC (13-14) -Measuring

<i>Objectives</i>	Publication 1	Publication 2	Publication 3	Publication 4	Publication 5	Publication 6
					(7) - Forensic evidence (23) -Magnification for injury detection (26) -Rape crisis advocates (40) -Timeline of legislation (67-9)	hospital services (15) -Providing care to survivors with mental illness (20)
<i>Objective 4: Services & Survivors' Satisfaction</i>	-Secondary victimisation: negative interactions with service providers (40) -RCPs (47)	-Under -reporting of SV (28) -Disclosure and help-seeking (58)	-	-Help-seeking behaviours (321)	-RCPs (40)	-Defining satisfaction (5) -RCPs (25) -Measuring satisfaction (25, 34, 44) -Law enforcement in NYC (33) -Criminal justice services (43) -Services to survivors with disabilities (48)
<i>Objective 5: Recommendations</i>	-Public health approach (47) -Combatting CSEC (49) -Antitrafficking (50)	-	-	-Peer help-giving (332)	-QA frameworks (43)	-Patient centred care

Appendix 2: Summary of Validated Instruments Used in Body of Work

Measures	Purpose	Specifics of Instrument	Recoding	Related Study & Study Objective	Reliability	Citation
Conflict in Adolescent Dating Relationship Inventory (CADRI)	Past year prevalence of using and receiving dating violence during a conflict or argument	<p>25 questions with five subscales:</p> <ul style="list-style-type: none"> -Sexual abuse subscale (four questions) -Threatening behaviour subscale (four items) -Relational aggression (three items) such as 'He/she tried to turn my friends against me', etc. -Physical abuse (four items) -Emotional and verbal abuse (ten items) 	Various types of recoding including following the original scales, the development of new scales and the creation of dichotomous variables.	Partners and Peers study to fulfil objective 1 on prevalence	<p>Sexual abuse $\alpha = .51$</p> <p>Threatening behaviour $\alpha = .66$</p> <p>Verbal and emotional abuse $\alpha = .82$</p> <p>Relational aggression $\alpha = .52$</p> <p>Physical abuse $\alpha = .83$</p>	Wolfe, D. A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A. L. (2001). Development and validation of the Conflict in Adolescent Dating Relationships Inventory. <i>Psychological Assessment, 13</i> , 277-293.

Measures	Purpose	Specifics of Instrument	Recoding	Related Study & Study Objective	Reliability	Citation
Dating Violence Inventory (DVI)	Lifetime prevalence of experiencing violence from an intimate partner	<p>23 questions with three subscales:</p> <ul style="list-style-type: none"> -Physical abuse subscale (ten questions) -Sexual abuse subscale (two questions) -Verbal abuse subscale (ten questions) <p>Respondents were asked how often in their lives (ranging from “never” to “4 or more times”) a current or previous partner had used physical relationship violence against them (e.g., “Slapped or hit you,” “Punched you,” “Choked you”) and sexual relationship violence against them (e.g., “Tried to force you into sexual activity,” “Raped you”).</p>	For the purpose of analyses, the scale was followed.	Partners and Peers study to fulfil objective 1 on prevalence	<p>DVI overall $\alpha = .90$</p> <p>Physical abuse $\alpha = .84$</p> <p>Verbal abuse $\alpha = .90$</p>	Symons, P.Y., Groer, M.W., Kepler-Youngblood, P., and Slater, V. (1994). Prevalence and predictors of adolescent dating violence. <i>J Child Adolesc Psychiatr Nurs</i> .7(3): 14–23.
WHO Multicountry study on women’s health and domestic violence against women	History of controlling behaviour	Measured using question 703 from the WHO multicountry study asks about both use and receipt of ‘tries to keep you from seeing your friends’, ‘tries to restrict contact with your family’, ‘insists on knowing where you are at all	For the purposes of various analyses, a dichotomous variable was constructed in which respondents were	Partners and Peers study to fulfill objective 1 on prevalence	N/A	Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. <i>WHO multi-country study on women’s health and domestic violence against women: Initial results</i>

Measures	Purpose	Specifics of Instrument	Recoding	Related Study & Study Objective	Reliability	Citation
		times', 'ignores you and treats you indifferently', 'gets angry if you speak to another man/woman', 'is often suspicious that you are unfaithful' with two additional researcher developed questions about the partner (or respondent) checking the other person's cell phone and email messages.	categorized as either having experienced at least one incident of relationship violence victimization (coded 1) or not (coded 0).			<i>on prevalence, health outcomes, and women's responses.</i> Geneva, Switzerland: World Health Organization, 2005.
Youth Risk Behavioural Survey		<p>Questions from YRBS taken on youth violence: 1. During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school? (missed school)</p> <p>2. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club? (Carrying a weapon)</p> <p>3. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club? (Threatened/injured with a weapon)</p>	dichotomous variables were constructed for 'missed school', 'carrying a weapon', 'threatened/injured with a weapon', 'participated in a fight' and 'gang membership'	Partners and Peers study to fulfill objective 2 on the nature and impact	Used individual questions	<p>New York City Department of Health and Mental Hygiene, Department of Education, & National Centers for Disease Control and Prevention. (2007). New York City Youth Risk Behavior Survey. Retrieved from http://www.nyc.gov/html/doh/html/data/youth-risk-behavior.shtml</p> <p>Centers for Disease Control and Prevention. (2006).</p>

Measures	Purpose	Specifics of Instrument	Recoding	Related Study & Study Objective	Reliability	Citation
		<p>4. During the past 12 months, how many times were you in a physical fight? (Participated in a fight)</p> <p>5. At any time during the past 12 months, have you been a member of a gang? (Gang membership)</p>				Youth risk behavior surveillance: United States, 2005. <i>Morbidity and Mortality Weekly Report: Surveillance Summaries</i> , 55(5), 1-108.
Child Health and Illness Profile – Adolescent Edition (CHIP-AE)	Health and well-being measurements	'Partners and Peers' utilised the following subscales of the CHIP-AE: satisfaction with health, physical discomfort, self-esteem and emotional discomfort as well as several items from the resilience subscale.	Coded according to the scales.	Partners and Peers study to fulfill objective 2 on the nature and impact	<p>Satisfaction with health and self-esteem (12 items) $\alpha = .89$</p> <p>Discomfort (45 items) $\alpha = .89$</p> <p>Resilience (32 items) $\alpha = .78$</p>	Riley, A.W., Green, B., Forrest, C.B., Starfield, R., Kang, M., and Ensminger, M. (1998). A taxonomy of adolescent health: Development of the adolescent health profile types. <i>Medical Care</i> , 36: 1228-1236.
Family Abuse Scale with researcher added questions and definition of sexual abuse	Ever experience various forms of child sexual abuse	The questions were preceded in the survey by a definition of sexual abuse. Respondents were then asked in five separate items which expands on the two item Family Abuse scale, "How often in your life has...your parent sexually	In analyses, child sexual abuse was coded as a dichotomous variable, where respondents were categorized as	Partners and Peers study to fulfill objective 1 on prevalence	Family abuse scale $\alpha = .65$	Symons, P.Y., Groer, M.W., Kepler-Youngblood, P., and Slater, V. (1994). Prevalence and predictors of adolescent dating violence. <i>J Child</i>

Measures	Purpose	Specifics of Instrument	Recoding	Related Study & Study Objective	Reliability	Citation
		abused you or forced you to have sex...a family member other than a parent sexually abused you or forced you to have sex...an older acquaintance (such as a family friend, teacher, minister, neighbor, etc.) sexually abused you or forced you to have sex...someone else your age who you knew but was not your partner sexually abused you or forced you to have sex....and a stranger sexually abused you or forced you to have sex?" Response categories ranged from "never" to "4 or more times."	either having experienced at least one child sexual abuse incident or not.			<i>Adolesc Psychiatr Nurs</i> 7(3): 14–23.

Appendix 3: Summary of Newly Developed Scale Measures in the Body of Work

Measures	Purpose	Construction of Measure	Reliability	Construct Validity
Verbal reasoning used	Used in multivariate models related to adolescent communication and violent behaviours in relationships	Verbal reasoning was developed using six items from the CADRI on using the following strategies during a conflict or argument with the respondent's partner in the last year: "I told him that I was partly to blame," "I agreed that he was partly right," "I gave reasons why I thought he was wrong," "I offered a solution that I thought would make us both happy," "I discussed the issue calmly," and "I told him how upset I was."	Young adult Clinic sample (YAC): $\alpha = .86$ Adolescent clinic sample (AC): $\alpha = .78$ Adolescent School sample (ASch): $\alpha = .78$	Consequential- Yes Content- Yes Substantive- Yes Structural- Yes External- Yes Generalizability- Yes
Verbal reasoning received	Used in multivariate models related to adolescent communication and violent behaviours in relationships	Verbal reasoning received was developed using the same six items as 'Verbal reasoning used' and measures the extent to which the respondent's partner used these strategies towards the respondent during a conflict or argument in the last year.	YAC: $\alpha = .84$ AC: $\alpha = .79$ ASch: $\alpha = .78$	Consequential- Yes Content- Yes Substantive- Yes Structural- Yes External- Yes Generalizability- Yes
Temporary conflict avoidance used	Used in multivariate models related to adolescent communication and violent behaviours in relationships	Conflict avoidance used was developed with two items from the CADRI instrument: "I left the room to cool down," and "I put off talking until we calmed down." The type of avoidance referred to by these two items is not permanent but temporary, the purpose of which presumably is to dampen tensions and allow the	YAC: $\alpha = .64$ AC: $\alpha = .61$ ASch: $\alpha = .52$	Consequential- Yes Content- Yes Substantive- Yes Structural- Yes

Appendix 3: Summary of Newly Developed Scale Measures in the Body of Work

Measures	Purpose	Construction of Measure	Reliability	Construct Validity
		conflict to be more easily dealt with at a later time.		External- Yes Generalizability- Yes
Temporary conflict avoidance received	Used in multivariate models related to adolescent communication and violent behaviours in relationships	Conflict avoidance received uses the same two items as 'conflict avoidance used' but instead measures the respondent's receipt of these strategies used by their partner during a conflict or argument in the previous year.	YAC: $\alpha = .66$ AC: $\alpha = .64$ ASch: $\alpha = .46$	Consequential- Yes Content- Yes Substantive- Yes Structural- Yes External- Yes Generalizability- Yes
Escalating strategies used	Used in multivariate models related to adolescent communication and violent behaviours in relationships	Escalating strategies was operationalised as using any combination of movement-restricting strategies: "I accused him of flirting with someone else" or "I kept track of who he was with and where he was" as well as and verbally aggressive strategies: "I threatened to end the relationship," "I did something to make him feel jealous," "I said things just to make him angry," "I spoke to him in a hostile or mean tone of voice," "I insulted him with put-downs," "I ridiculed or made fun of him in front of others," "I blamed him for the problem," and "I brought up something bad that he had done in the past."	YAC: $\alpha = .89$ AC: $\alpha = .86$ ASch: $\alpha = .86$	Consequential- Yes Content- Yes Substantive- Yes Structural- Yes External- Yes Generalizability- Yes

Appendix 3: Summary of Newly Developed Scale Measures in the Body of Work

Measures	Purpose	Construction of Measure	Reliability	Construct Validity
Escalating strategies received	Used in multivariate models related to adolescent communication and violent behaviours in relationships	‘Escalating strategies received’ uses the same ten items as the ‘escalating strategies used’ but instead measures the respondent’s receipt of these strategies as done by a partner during a conflict or argument in the previous year.	YAC: $\alpha = .90$ AC: $\alpha = .86$ ASch: $\alpha = .86$	Consequential- Yes Content- Yes Substantive- Yes Structural- Yes External- Yes Generalizability- Yes
Help-giving: Suggesting options	Used in multivariate models related to adolescent help-giving	Suggesting options to their friend as a help-giving subscale was assessed through four items asking, “Have you given this friend advice?,” “Have you told him/her to call a hotline?,” “Have you told him/her to talk to an adult?,” and “Have you told him/her to leave this partner?”	$\alpha = .53$	Consequential- Yes Content- Yes Substantive- No/Unsure Structural- Yes External- No/Unsure Generalizability- No/ Unsure
Help-giving: Taking Action	Used in multivariate models related to adolescent help-giving	Taking action on behalf of or with the victim was assessed through four items asking, “Have you called a hotline to figure out how to help your friend?,” “Have you gone with your friend to get some help like at a clinic?,” “Have you talked to the partner directly about his/her violence?,” and “Have you talked to an adult	$\alpha = .51$	Consequential- Yes Content- Yes Substantive- No/Unsure Structural- Yes External- No/Unsure Generalizability-

Appendix 3: Summary of Newly Developed Scale Measures in the Body of Work

Measures	Purpose	Construction of Measure	Reliability	Construct Validity
		about your friend's problem?"		No/ Unsure

Appendix 4: Summary Overview of Data Analyses Conducted in the Body of Work

Purpose of Analysis or Hypothesis Tested	Analysis Conducted	Notes on Choice of Analysis and Variables	Associated Publication
To explore the distribution, frequency and other key descriptive statistics of all the quantitative data.	Univariate analyses conducted for all variables	Univariate analyses were conducted first for all questions of interest in order to determine appropriate statistical analyses for further exploration.	Publications 2-6,
To explore the self-reported functional health status of adolescents who use or receive violence in their current relationship or who have ever received violence in a relationship	Multivariate regression analysis	Controlling for potential confounders (gender, ethnicity, country of birth, and non-partner sexual abuse).	Publication 2
Hypothesis: Escalating strategies <i>used</i> and avoidance and reasoning <i>received</i> affect physical violence <i>used by young women</i>	Negative binomial regression	Negative binomial regression is suited for dependent variables measuring an event frequency for which the probability of occurrence shifts over time. This model was run with the young adult clinic subsample No. 1, adolescent clinic subsample No. 1, and adolescent school subsample No. 1 (violence used by the women).	Publication 3
Hypothesis: Escalating strategies <i>used</i> and avoidance and reasoning <i>received</i> affect violence <i>received</i> ,	Negative binomial regression	Each use-receipt communication variable set was split into separate models for multivariate analysis due to strong multicollinearity within each set (within-set correlations: young adult clinic sample, $r = .73-.88$; adolescent clinic sample, $r = .63-.89$; adolescent school sample, $r = .71-.87$) and far lower correlation coefficients for bivariate associations across strategy types. This model was run with the young	Publication 3

		adult clinic subsample No. 2, adolescent clinic subsample No. 2, and adolescent school subsample No. 2 (violence received by the women).	
Hypothesis: Escalating strategies <i>received</i> and avoidance and reasoning <i>used</i> affect violence <i>used</i>	Negative binomial regression	This model was run with the young adult clinic subsample No. 1, adolescent clinic subsample No. 1, and adolescent school subsample No. 1 (violence used by the women).	Publication 3
Hypothesis: Escalating strategies <i>received</i> and avoidance and reasoning <i>used</i> affect violence <i>received</i>	Negative binomial regression	This model was run with the young adult clinic subsample No. 2, adolescent clinic subsample No. 2, and adolescent school subsample No. 2 (violence received by the women).	Publication 3
To determine if the odds of disclosing relationship violence or non-partner sexual violence to anyone by the time of the survey was associated with gender, Latino ethnicity, or nativity	Bivariate logistic regression	These analyses were conducted in a bivariate rather than multiple variable regression analysis due to the smaller model sample sizes.	Publication 4
To determine if the odds of who was disclosed to first, a friend or an adult, was associated with gender, Latino ethnicity, or nativity.	Bivariate logistic regression	These analyses were conducted in a bivariate rather than multiple variable regression analysis due to the smaller model sample sizes.	Publication 4
To determine if gender, Latino ethnicity, or nativity was associated with the odds of ever only disclosing relationship violence or non-partner sexual violence to friends by the time of the survey, relative to ever disclosing to any adult.	Bivariate logistic regression	These analyses were conducted in a bivariate rather than multiple variable regression analysis due to the smaller model sample sizes.	Publication 4

To determine whether the help-giver's history of child sexual abuse or dating violence victimisation was associated with talking with their friend, suggesting options, and taking action with or on behalf of their friend in a violent relationship.	Bivariate logistic regression	These analyses were conducted in a bivariate rather than multiple variable regression analysis due to the smaller model sample sizes.	Publication 4
To explore whether gender, Latino ethnicity, and nativity were associated with talking with their friend, suggesting options, and taking action with or on behalf of their friend in a violent relationship.	Multiple variable logistic regression	Since the help-giver's personal experiences of child sexual abuse and dating violence victimisation were not significant predictors of help-giving behaviors in the bivariate analyses, they were not included in the multiple variable regression model in the interest of model parsimony and statistical power.	Publication 4
To explore the differences between public and private hospitals and between SAFE Centers and non-SAFE hospitals on the services offered	Independent t-test	To test differences in the means.	Publication 5
To explore the differences between emergency department located in different boroughs of NYC and the services offered	ANOVA	To test differences between borough means. Further examination of differences was conducted using Tukey's Ad hoc comparison with equal variances assumed.	Publication 5
To determine what difference, if any, exists between the ED Director and ED clinician responses on the services provided	Independent T-tests	Used to test the difference in means.	Publication 5

Appendix 5: Summary Overview of Missing Data for Key Analyses

Paper No.	Missing Data on Key Variables	Pattern of Missingness	How Missing Data was Handled
3	<p>There were no missing data in the adolescent & young adult clinic samples. In the adolescent school sample, there were missing cases for</p> <ul style="list-style-type: none"> -physical violence used ($n = 1$) -physical violence received ($n = 34$), -reasoning used ($n = 17$) -reasoning received ($n = 41$), -avoidance used ($n = 7$) -avoidance received ($n = 38$), -escalation used ($n = 30$) -escalation received ($n = 44$), -experiencing child sexual abuse ($n = 14$), -relationship importance ($n = 4$) -relationship length ($n = 2$), -times pregnant ($n = 13$), -race-ethnicity variables ($n = 59$) -months exposed to the CADRI time frame ($n = 12$). 	<p>Missing at Random (MAR), with missingness on several of the communication variables significantly associated with lower mean scores on other communication and violence variables (t tests, $p < .05$)</p>	<ol style="list-style-type: none"> 1. Pairwise deletion of missing cases for bivariate descriptive analysis of the adolescent school data 2. To account for patterns of missingness in multivariate analysis of the adolescent school sample, multiple imputation was used with five iterations generated for each model analyzed, each time using all the variables for that given model during the imputation process
4	Of the full sample of 1,312 respondents, minimal data were	Of the variables with the	Given that little data were missing,

Appendix 5: Summary Overview of Missing Data for Key Analyses

Paper No.	Missing Data on Key Variables	Pattern of Missingness	How Missing Data was Handled
	<p>missing on</p> <ul style="list-style-type: none"> -gender (missing n=1), -Latino ethnicity (n=2), -national origin (n=7), -age (n=6), -history of child sexual abuse (n=41), -help-seeking variables (n=40), -whether the respondent ever had a friend in a violent relationship (n=58). <p>Of those who reported having a friend in a violent relationship, few respondents did not complete the help-giving items on</p> <ul style="list-style-type: none"> -talking to their friend (n=6), -suggesting options (n=10), -taking action (n=9). <p>- only two respondents did not complete all of the survey items on lifetime physical and sexual relationship violence victimization history</p>	<p>greatest missing data (child sexual abuse, help-seeking, and having a friend disclose relationship violence), two thirds of respondents had missing data on only one of these variables. Males were significantly less likely than females to answer the help-seeking items and the item regarding whether a friend had disclosed relationship violence.</p>	<p>listwise deletion of missing cases was used for analyses</p>

Publication 1

O'Sullivan, C. and Fry D. (2007). *Sexual Assault Victimization Across the Lifespan: Rates, Consequences and Interventions for Different Populations*. Victims of Crime, RC Davis, A. Lurigio & S. Herman, editors, 3rd edition. London: Sage.

Copyright permission obtained from Sage Book Publications and the co-author of this publication to use and archive this book chapter within this PhD by Publications thesis.

3

Sexual Assault Victimization Across the Life Span

Rates, Consequences, and Interventions for Different Populations

CHRIS S. O'SULLIVAN

DEBORAH FRY

Sexual violence represents a large public health problem across the globe. Sexual violence is defined as

any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or [acts] otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. (WHO, 2002)

In one year alone in the United States, there were 209,880 victims aged 12 and older of rape, attempted rape, or sexual assault according to the National Crime Victimization Survey

(NCVS; Catalano, 2005). Through a quasi-experimental design, however, Fisher, Cullen, and Turner (2000) found that the NCVS methodology leads to an undercount of sexual assaults. The National Violence Against Women Survey (NVAWS; Tjaden & Thoennes, 2000) found that 15% of U.S. women over the age of 17 reported having been raped.

Younger women are particularly vulnerable. A survey conducted with a randomly selected national sample of college women (Fisher et al., 2000) found a victimization rate of 28 rapes per 1,000 female students in just over six months. Because some women were victimized more than once in this period, the incidence was higher than the

prevalence. Twenty-three percent were raped more than once. The study estimated that over the course of a college career (which now lasts an average of five years), between one fifth and one fourth of college women may experience completed or attempted rape. Internationally, up to one third of adolescent girls report that their first sexual experience was forced (WHO, 2002).

Childhood is also a time of high risk for sexual assault, especially for boys. The NVAWS found that 22% of female victims of sexual assault and 48% of male victims were under the age of 12 when they were first raped (Tjaden & Thoennes, 2006). (Note that the survey conducted from 1994 to 1996 is referred to as the National Violence Against Women Survey, but the sample included random samples of 8,000 women and 8,000 men.)

Contrary to the image of the rapist lurking in the shadows to surprise and victimize a solitary stranger, two thirds of the rapes of victims over the age of 12 were committed by someone known to the victim. A friend or acquaintance of the victim committed nearly half the rapes (Catalano, 2005). Men are more likely to be raped by strangers (29%) than women (17%; Tjaden & Thoennes, 2006). Attackers of college women are even more likely to be known to the victim: The National College Women Sexual Victimization Survey (Fisher et al., 2000) found that 90% of the offenders were known to their victims.

Rapes of women by male intimate partners are a global problem. In a 10-country study of violence against women, the World Health Organization (WHO) found that rates of sexual violence perpetrated by male partners ranged from a low of 6% in Japan to a high of 59% in Ethiopia (WHO, 2005). The WHO study provides one of the first cross-country examinations of patterns of partner violence. In most of the countries in the study, 30% to 56% of women who had experienced any violence by an intimate partner reported

both physical and sexual violence (WHO, 2005). This pattern did not hold true for all sites, however: Across Thailand and in provincial Bangladesh and Ethiopia, a large proportion of women experienced sexual violence only.

This chapter will review research findings on sexual victimization of children, adolescents, and adults. It will cover the emerging topics of commercial sexual exploitation of children, sex trafficking, rape by intimate partners, and prison rape. It will conclude with recommendations for future research and new directions in practice.

SEXUAL VIOLENCE FROM INFANCY TO ADULTHOOD

Sexual Abuse of Children

Although the maximum age varies across definitions, child sexual abuse is generally defined as unwanted sexual activity with a child from birth to 14 years old, or sexual activity with a person 5 years or more older than the child. In 2000, the rate of substantiated sexual abuse for children under the age of 3 was 15.7 victims per thousand. Unlike other forms of child abuse, child sexual abuse is more often perpetrated against girls than boys. In a retrospective study, Finkelhor, Hotaling, Lewis, and Smith (1990) estimated that 27% of American women and 16% of men had been sexually abused as children; the median age of the children at the time of the abuse was between 9 and 10 years old. Girls are more at risk of sexual victimization than boys at any age, but the age of highest risk for boys is in childhood, whereas for girls it is more evenly distributed into young adulthood, although peaking in adolescence. In the NVAWS, among male respondents who had ever experienced rape or attempted rape, 71% were younger than 18 when they were first sexually assaulted, and 48% were younger than 12 years old.

Like adults, juveniles (birth to 17 years of age) are most often sexually assaulted by someone they know: acquaintances—such as family friends, neighbors, and baby-sitters—commit 59% of rapes of children. Juveniles, however, are more likely than adults to be assaulted by relatives: Family members commit 34% of child rapes (Snyder, 2000). Perpetrators are overwhelmingly male, whether the victim is a boy (86% male perpetrators) or a girl (94% male perpetrators). Children with disabilities (both physical and cognitive) are believed to be more vulnerable to sexual abuse.

Child sexual assault cases represent over one third of sexual assaults reported to law enforcement: According to the FBI's National Incident Based Reporting System, from 21 states from 1991 to 2000, 34% of sexual assault victims are younger than 12 years old, and 14% are younger than 6 years old. Still, sexual assaults of child victims can be difficult to substantiate. Children often do not disclose sexual abuse because they believe the situation is normal, blame themselves, are afraid of the consequences, and/or feel they will not be believed. These barriers to reporting are often reinforced by the perpetrator. Physical signs of sexual abuse may not be apparent, although when there is investigation, detection has improved.

Emotional and Physical Impact

Observable signs of sexual abuse in children include agitation, frightening dreams, and age inappropriate sexual behavior. Symptoms include depression to the point of suicidality, even in children as young as four years old; withdrawal; and traumatic stress (Boney-McCoy & Finkelhor, 1995). Boys who have been sexually violated are more likely than girls to act out with aggressive and cruel behavior. (Seventy-six percent of incarcerated male serial rapists claim to have been sexually abused as children.)

The psychological effects of childhood sexual abuse may be manifested in adolescence and early adulthood in the form of delinquency, multiple sexual partners, and suicide attempts. These effects persist into adulthood, including a higher rate of substance abuse, particularly alcohol abuse, and eating disorders; multiple consensual sexual partners with attendant risks of sexually transmitted diseases (STDs); depression; dissociation; problems forming relationships; and educational underachievement and underemployment. There is also a high risk for revictimization (see Daigle, Fisher, & Guthrie, in this volume). Survivors of childhood sexual abuse not only exhibit lasting psychopathology but also continue to seek psychological treatment.

Not only is child sexual abuse, especially incest, hidden within the family, but for many decades it was also hidden from awareness of professionals and the criminal justice system by Freudian theory, which attributed memories of incest to Oedipal longings. Several books altered that awareness, including Geoffrey Masson's questioning of the development of Freud's own views of the reality of these memories (1984), and research by Judith Herman (*Father-Daughter Incest*, 1981) and Diana Russell (*The Secret Trauma: Incest in the Lives of Girls and Women*, 1986). The trauma from incest and child sexual abuse was persuasively and influentially described in Judith Herman's *Trauma and Recovery* (1992b), which quickly became a classic for therapists. There is still much controversy surrounding the question of "recovered memories" of childhood sexual abuse, however.

Continuing research on child sexual abuse and trauma has been led by John Briere (cf. Briere & Runtz, 1990) and David Finkelhor, and Angela Browne has focused on lasting effects into adulthood, particularly among poor, homeless, and incarcerated women. Finkelhor and Browne developed the "traumogenic" model of childhood sexual abuse

(1985). According to this model, there are four dynamics that result from sexual abuse of young children: (1) traumatic sexualization (which may take two pathways: avoidance of sex and heightened interest in sex); (2) betrayal, because the perpetrator is usually a trusted adult; (3) powerlessness; and (4) stigmatization, which leads the child to feel different, damaged, and inherently bad. More severe abuse, as defined by sexual contact involving penetration (i.e., rape), greater use of force and threats, and injury, has been found to be associated with more symptoms. Other factors that increase the probability of traumatic stress symptoms and psychopathology include longer duration of the abuse or repeated assaults and a closer relationship with the perpetrator. Adults are more likely to be symptomatic if these characteristics pertained to their childhood abuse. Researchers at the University of Wisconsin, Yale, and in London have been investigating the environmental and genetic factors associated with "resilience": A minority of adults who experienced severe sexual abuse in childhood do not suffer from depression, drug addiction, and problems with trust. There appear to be both biological and social factors (e.g., the presence of a supportive adult) that are protective (Bazelon, 2006).

Sexual Victimization of Youth

Youth is generally defined as the age range from 10 to 24, with subcategories of adolescence, ranging from 10 to 19 years old, teenage years ranging from 13 to 19, and young adults from 20 to 24 years old (UN, 2006). Although there may be differing conceptualizations of this life stage, there is no dispute that sexual violence disproportionately affects women in these age ranges. The NCVS indicated that adolescent females ages 16–19 are four times more likely than the general population to experience sexual assault, rape, and attempted rape (Rennison, 2002).

Increasingly, studies have shown that many girls' first sexual encounter is forced. In a multicountry study in the Caribbean, nearly half of sexually active adolescent women reported that their first sexual encounter was forced (Halcón, Beuhring, & Blum, 2000). Likewise, in Lima, Peru, nearly 40% of young women reported forced sexual initiation as compared to only 11% of the young men (Caceres, Vanoss, & Hudes, 2000). Recent research has focused on sexual violence in young people's dating relationships. One study found that one in five female high school students reported experiencing physical and/or sexual violence from a dating partner (Silverman, Raj, Mucci, & Hathaway, 2001). The National Center for Juvenile Justice estimates that in two thirds of sexual assaults reported to law enforcement agencies in the United States, the victim was under the age of 18 at the time of the crime. These numbers are surprising given that reported violence is often just the tip of the iceberg. Sexual violence is often referred to as a "hidden crime" or "silent epidemic" because rape and sexual assault are so frequently not reported to the police and other authorities (Harner, 2003). Adolescents are particularly likely to hide a rape if they were intoxicated or engaged in other illegal or unapproved behavior. Fisher et al. (2000) noted that, of college women who described experiencing a sexual act that meets the legal definition of rape, fewer than 47% defined the experience as rape.

Sexual Violence Against Homeless Youth

Homeless youth are one of the most vulnerable populations (Ensign & Santelli, 1998). It is estimated that nearly 2 million youth are homeless in the United States (Rew, Taylor-SeeHafer, & Fitzgerald, 2001). Homeless youth include runaways, who have left their homes without permission; "throw-aways," who have been forced to leave home; and "street-involved" youth, who spend most

of their time on the street with peers and may have a home to which they can return (Rew et al., 2001). In addition to increasing risk of sexual victimization, homelessness is also a result of sexual violence. Abuse in the family is often pivotal in the decision to run away (Molnar, Shade, Kral, Booth, & Watters, 1998; Rew et al., 2001). Sexual minority youth (homosexual, bisexual, and transsexual) are particularly likely to be thrown out of their homes by their parents.

Rates of prior sexual abuse among homeless youth range from 32% to 60% (Noell, Rohde, Seeley, & Ochs, 2001; Rew et al., 2001; Tyler & Cauce, 2002). As with all sexual victimization of children, perpetrators were most likely to be nonfamily adults (58%) or a nonparent relative such as an older sibling or uncle (25%). Biological parents (10%), stepparents, and foster or adoptive parents (7%) were least likely to be the perpetrators of sexual abuse (Tyler, Whitbeck, Hoyt, & Cauce, 2004). Among homeless youth, girls experienced higher rates of sexual abuse than boys before leaving home, and sexual minority youth experienced higher rates of both physical and sexual abuse than heterosexual youth. A very high percentage (92%) of the homeless youth had told someone about experiencing sexual abuse.

After they leave home, sexual victimization of homeless youth remains higher than for their peers. Tyler and colleagues (2004) found that 23% of homeless girls and 11% of homeless boys had experienced sexual victimization at least once since being on the street. In part, this increased risk can be attributable to the higher rate of sexual assault of the previously victimized: Experiences of sexual abuse and combined physical and sexual abuse prior to becoming homeless were precursors to on-street rape (Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000). In addition, there are risks in homelessness and the associated lifestyle. Several studies have found that approximately 25% of homeless youth engage in survival

sex, that is, trading sex for food, shelter, or money, increasing their vulnerability to sexual assault (Greene, Ennett, & Ringwalt, 1999; Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Kral, Molnar, Booth, & Waters, 1997). Females were most often victimized by male acquaintances (41%), then by male strangers (34%), and by male friends (23%). In contrast, homeless male youth reported being sexually victimized most often by strangers (56%), then by acquaintances (32%). Similar to females, 71% of the young men reported experiencing sexual victimization at the hands of other males (Tyler et al., 2004). Compared to other homeless youth, those who have been sexually abused report higher rates of suicide attempts, abuse of alcohol and drugs, and negative coping strategies (Cohen, Spirito, & Brown, 1996; Molnar et al., 1998; Rew et al., 2001; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996).

Sexual Victimization in Adulthood

The WHO Report on Violence and Health compiled several studies of the prevalence of sexual assault of adults across countries. The estimates range from less than 2% of the entire population in La Paz, Bolivia, and Beijing, China, to 5% or more in Tirana, Albania, and Rio de Janeiro, Brazil (WHO, 2002). In the United States, more than 300,000 women (0.3%) and more than 90,000 men (0.1%) reported being raped in the previous year. One in 6 women (17%) and 1 in 33 men (3%) reported experiencing an attempted or completed rape at some point during their lifetime: American Indian and Alaskan native women were more likely than other racial/ethnic groups to be raped. This finding is consistent with other research showing this group to experience more violent victimizations other than rape (Tjaden & Thoennes, 2000).

Nearly a third of the women and half as many men were injured during their most

recent rape, but most of the injuries were minor—such as scratches, bruises, and welts. A third of the women and a fourth of the men sought mental health counseling in regard to the rape. About 1 in 5 of the women and 1 in 10 of the men raped in adulthood reported the rape to authorities. Counting all rapes these victims experienced since the age of 18, only 8% of the cases were prosecuted, 3% resulted in a conviction, and 2% of the perpetrators were incarcerated (Tjaden & Thoennes, 2000). As with sexual violence committed against children and adolescents, perpetrators of sexual assault of adults are usually known to the victim. Risk factors for rape in adulthood include prior victimization, alcohol abuse, and multiple sexual partners, including consensual sexual partners.

REVICTIMIZATION

“Revictimization” was originally used to refer to victim blaming, questioning of credibility, and other harsh treatment many survivors face from the criminal justice agents and health care providers when they attempt to report a rape. This treatment has been termed “the second rape” or secondary victimization. Of late, “revictimization” has come to refer more commonly to new incidents against someone who has already experienced sexual assault—usually being reassaulted by a different perpetrator or perpetrators. This use has grown because many studies have found that a survivor of sexual violence is more likely to be sexually revictimized than someone who has not been previously abused.

Secondary Victimization: Negative Interactions With Service Providers

Survivors of sexual violence often turn to a variety of services after an assault. They may seek medical care or counseling services, report the assault to the police, and/or work with prosecutors in a legal case. Often survivors

are treated poorly by the very systems set up to help them. Secondary victimization has been defined as the victim-blaming attitudes, behaviors, and practices engaged in by community service providers that result in additional trauma for rape survivors (Campbell & Raja, 1999). Examples include asking victims how they were dressed, questioning them about their sexual histories, asking if they were sexually turned on by the assault, or encouraging them not to prosecute (Campbell & Raja, 1999). Such treatment increases rape survivors’ feelings of guilt, depression, and distrust and their reluctance to seek further help (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001).

A recent study by Rebecca Campbell (2005) compared victims’ accounts of what happened during service delivery with those of doctors, nurses, and police officers. Police officers and doctors significantly underestimated the impact they were having on survivors. Victims reported more subsequent distress about their contacts with the medical and criminal justice systems than service providers thought they were experiencing.

Repeat Sexual Assault

Women who are raped are usually raped more than once: Among adults who report being raped in the previous year, women experienced 2.9 rapes, and men experienced 1.2 rapes. A study of women with disabilities found that 80% were sexually victimized more than once (Sobsey & Doe, 1991). Sexual abuse early in life has been particularly implicated in vulnerability to repeat sexual victimization, and there is a growing literature on this relationship, the risk factors and psychological correlates, and interventions. Perhaps the first study to uncover the correlation between childhood sexual abuse and rape in adulthood was a study of incest survivors conducted by Diana Russell (1986). In a retrospective study of 152 women who

had experienced interfamilial sexual abuse (incest) before the age of 14, Russell found that 63% also experienced rape or attempted rape after the age of 14. More information on revictimization can be found in the chapter by Daigle, Fisher, and Guthrie (in this volume).

EMERGING TOPICS

Commercial Sexual Exploitation of Children

The commercial sexual exploitation of children (CSEC) involves sexual abuse primarily or entirely for financial benefit. The economic exchanges involved in the sexual exploitation may be either monetary or non-monetary (e.g., for shelter, drugs, or trade for other sexual exploitation of children) but, in every case, provides the greatest benefits to the exploiter and a violation of the rights of the children involved (Hughes & Roche, 1999). Forms of CSEC include trafficking of children for sexual purposes, prostituting of children, sex tourism, the mail order bride trade, and pornography (Estes & Weiner, 2001; Hughes & Roche, 1999). Much sexual exploitation of children is domestic, but the Internet and globalization have expanded and exacerbated the problem.

According to the international nongovernmental organization (NGO) End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes (ECPAT), the U.S. Department of Justice estimates the number of children exploited through prostitution, pornography, and sex trafficking in the United States to be between 100,000 and 3 million. Some victims of prostitution are as young as 9 years old, and many are only 11 or 12, but the average age at which they are first commercially sexually exploited is 14. At least 25 to 30% of all those involved in commercial sexual exploitation are juveniles (ECPAT, 2006).

The theme of the UN-sponsored Second World Congress of Commercial Sexual Exploitation of Children was that CSEC is a global problem affecting rich and developed countries as well as poor and undeveloped countries (MOFA, 2001). The environmental factors contributing to CSEC include poverty, inequality, illiteracy, armed conflict, uncontrolled HIV/AIDS, and cultural values that do not regard child marriage or sex with children as a violation of human rights. Yet these factors are not fully explanatory: although child prostitution is most prevalent in countries with extreme poverty, hunger, and armed conflict, there are many poor countries where CSEC is not a major problem, and there are many developed countries where it is a significant problem. Additional contributing factors that may explain such discrepancies are discrimination against racial/ethnic groups and women and girls, criminality, and demand for children for sex (MOFA, 2001).

Child Pornography

Supreme Court chief justice Potter Stewart famously said in 1964 that it is difficult to define pornography, but "I know it when I see it." Child pornography is less subjective and ambiguous, defined simply as the "sexually explicit reproduction of a child's image." The United Nations Convention on the Rights of the Child, which has been ratified by a majority of member states, identifies child pornography as a violation of children's rights and requires nations to prevent the exploitative use of children in pornographic materials (USES, 1996).

ECPAT (2006) estimates that around 5 million images of child sexual abuse are in circulation on the Internet, featuring some 400,000 children. A recent case illustrates how the Internet has facilitated the globalization of CSEC. In 1998, an international law enforcement operation was targeted against a

pedophile ring of 180 members that called itself “w0nderland.” To become a member, one had to contribute new images of child pornography. Powerful gatekeeping and encryption devices protected the club. When police carried out their investigations, they found 750,000 pornographic images and 1,800 digitalized videos. A total of 1,236 exploited children were featured in these pictures and videos. Internationally, there were 107 arrests. The investigation found that the originator of “wonderland” was an American man living in New York.

“The Internet Porn Girl” and Masha’s Law. Mike Zaglifa, a suburban Chicago police sergeant working undercover, began trading images with a pornographer that provided horrific images of child sexual abuse. Zaglifa gave his correspondent’s IP address to the FBI, which traced the IP address to Matthew Mancuso, a wealthy, retired 46-year-old engineer living in a Pittsburgh suburb. Local police went to arrest Mancuso for purveying child pornography in 2003. They were surprised to find a little girl living with him: Masha was nearly 11 but the size of a 5-year-old because she had been malnourished by Mancuso to prevent her from growing and maturing. She immediately disclosed a history of abuse to the police. She was freed, adopted, and Mancuso was prosecuted. Meanwhile, the videos of Mancuso raping Masha were still on the Internet, and the Toronto police were concerned about the fate of the child. They conducted an international search to identify the child in the pornographic images and find her. Digitally removing her image, they released photographs to try to find out where the abuse was taking place: the location was identified as a Disney resort. By the time they finally tracked down the identity of the child in 2004, they learned that Masha had already been removed from her home with Mancuso and safely adopted by a woman.

Now 13, Masha testified before Congress in support of a bill sponsored by John Kerry

and told her story. Masha was adopted from a Russian orphanage when she was 5 by Mancuso, a divorced father of two. The adoption agencies failed to investigate the cause of the alienation of his daughters: He had molested them until they reached puberty. When Mancuso took his new daughter home, he made her sleep in his bed and began molesting her; eventually he began to rape her and photograph her. The more than 200 pornographic images he distributed on the Internet were a hot commodity. Referring not only to the pornography but also to the fact that Mancuso found the adoption agencies and her picture on the Internet, Masha testified, “The Internet is everywhere in my story. You need to do something right away,” and, because the pictures of her rapes are still being downloaded years after her abuser is in prison, “the abuse is still going on.” She said she is more upset about the continued consumption of those images than about the physical abuse. The Kerry-Isakson bill triples the civil damages that child Internet porn victims can recover from \$50,000 to at least \$150,000 (the penalty for downloading songs off the internet) and allows victims to sue after they have turned 18 if pornographic images of them as children are still being distributed (Kerry, Isakson Push for Tougher Penalties, 2005; *Masha’s Story*, 2006; Wikipedia, 2006).

Children can be harmed by pornography either through being forcibly exposed to it or by being filmed or photographed. Reviewing 1,202 prosecuted child sexual exploitation cases in the United States, Estes and Weiner (2001) found that 62% of the cases involved child pornography. These cases were split between those in which children were the subjects (370 cases) and those in which children were involuntarily exposed to child pornography (372 cases). The vast majority of these pornography cases were concentrated in three states: California (41%), Texas (31%), and New York (20%). As a

side note, less than 5% of the children in pornographic images have been identified.

Child Prostitution

Child prostitution differs from child sexual abuse in that it involves commercial exploitation, although the coercive use of power and control is similar. Defining a child as a person younger than 18, an estimated 1 million children worldwide are forced into prostitution each year, and the total number of prostituted children could be as high as 10 million (Willis & Levy, 2002). A study conducted jointly by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the National Center for Missing and Exploited Children found that physical, sexual, and psychological abuse are common in the families of female juvenile prostitutes (National Center for Missing and Exploited Children, 2002). For females, running away and childhood sexual victimization were two common pathways into prostitution (McClanahan, McClanahan, Abram, & Teplin, 1999).

Involvement in prostitution represents a range of negative health outcomes, including risk of sexual assault. Youth engaged in prostitution practice safer sex less frequently and have higher levels of drug use, including intravenous drugs, putting them at increased risk of contracting HIV and a wide range of STDs (Willis & Levy, 2002). In a study of 176 prostituted children in six countries by the Economic and Social Commission for Asia and the Pacific (ESCAP, 2000), HIV infection rates ranged from 5% in Vietnam to 17% in Thailand.

Prostituted children have very high levels of drug use, with three-fourths reporting that they abuse drugs or alcohol (Klain, 1999). A British study (Cusick, Martin, & Tiggey, 2003) found that chronic drug users—who were using crack cocaine, heroin, and non-prescription methadone—were least able to leave prostitution because they needed to

support their drug habit. They were most likely to be supporting a pimp's or boyfriend's drug habit and not operating independently. Dependence on a pimp further constrained their options in regard to leaving prostitution, choice of customers, and their ability to retain earnings. All of the prostitutes who were drug dependent in the sample of 125 had begun engaging in commercial sex before the age of 18. Another study found that prostitutes are more likely to be raped and otherwise violently assaulted by customers if they are using crack or heroin (Kurtz, Surratt, Inciardi, & Kiley, 2004).

Sex Tourism

The United Nations (1996) defines child-sex tourism as "tourism organized with the primary purpose of facilitating . . . a commercial sexual relationship with a child." It is difficult to measure the exact number of victimized children. One estimate is that there are 1 million children in prostitution in Asia, the primary destination for child sex tourists (Klain, 1999). (However, the U.S. State Department estimates that 1 million children are sexually exploited annually around the globe.) In a sample collected by ECPAT of foreign tourists visiting Southeast Asia to have sex with children, tourists from the United States represented the largest group of customers (1996).

Sex Trafficking

Trafficking can involve crossing international or domestic borders—or, according to a U.S. State Department fact sheet (2005)—it may not even involve transporting a person from one locale to another. Trafficking of human beings into forced labor and prostitution is also called "modern day slavery." In other words, even if the person was not coerced or duped into crossing borders, they will be considered "trafficked" if the conditions under which they live resemble captivity

or slavery. Under U.S. law, “severe forms of trafficking” include the recruitment, harboring, transportation, provision, or obtaining of a person for forced labor, resulting in debt bondage or slavery; a commercial sex act through the use of force, fraud, or coercion; or any commercial sex act if the person is under 18 years of age. The international NGO Coalition Against Trafficking in Women and Girls (CAT-W) instead draws on the 1949 UN resolution definition that considers all selling and buying of sex—all prostitution and other commerce in persons for sex—to constitute trafficking. Another term in use is “sexual slavery,” defined as being forced to engage in prostitution when the victim is unable to escape the situation, whether through the use or threat of force, actual captivity, or threats against the family, or fraud and deception. Sex trafficking involves not only prostitution but also working in so-called gentleman’s clubs, sex dancing, and forced participation in pornography.

NGOs working with trafficking victims find that about 50% have been trafficked into prostitution (DeWeese, 2004). The U.S. Department of Justice (DOJ) estimate of the proportion of sex trafficking is higher: According to the DOJ, of the 14,500–17,500 people trafficked into the United States each year, up to 70% are forced or coerced into commercial sex, including 23% girls and 10% boys under 18.

One successfully prosecuted case involved the Carreto family, which operated a prostitution ring recruiting poor and uneducated women from one town in Mexico. The traffickers smuggled them into the United States with false promises of marriage and work. Once in the United States, the women were moved around the country and forced into prostitution and servitude with a combination of threats, violence, and sexual abuse to keep them from fleeing or reaching out to authorities. The Carreto family kept their earnings.

Women are trafficked into prostitution in the United States not only from Mexico but also from Eastern Europe and Asia. In fact, the U.S. DOJ estimates that the largest number of trafficking victims into the United States come from East Asia and the Pacific (up to 7,000 annually). Sex trafficking is a global problem. For example, the director of a coalition of 25 Nigerian NGOs working on trafficking estimated that there are 50,000 Nigerian girls trafficked into prostitution in Italy, mostly from a single region of Nigeria where the parents do not consider the system to be trafficking (Musa, 2006). The U.S. DOJ estimates that trafficking provides up to \$10 billion in profits for organized crime.

A problem in combating sex trafficking is the assumption that prostitution is usually freely chosen and offers a level of remuneration otherwise unavailable to those without skills, education, or legal status to work. The State Department counters this argument by citing a study by Farley that 89% of women in prostitution want to escape and other research documenting the frequent violence and abuse that prostitutes experience from customers and pimps (Farley, 2003). Traffickers may also use sexual assault to control women forced into labor: Women trafficked into domestic servitude are often raped as well.

Intimate Partner Violence and Marital Rape

Since the 1980s, there has been a surge in research on domestic violence, or violence inflicted by current or former intimate partners. More recently, the frequent reports of sexual abuse as a component of intimate partner violence have been receiving attention, although there remains much research to be done in this area. The related topic of marital rape has received attention since at least 1978, when Laura X founded the National Clearinghouse on Marital and Date Rape. In part, the interest in marital rape

came from the legal community because of legal exemptions for husbands in rape statutes. In 1978, rape of a spouse was a crime in only four states; as of 1993, marital rape was a crime in all 50 states. In 30 states, however, there are exemptions if force is not used, even if the wife is incapacitated and unable to consent.

The topics of marital rape and rape as a component of intimate partner violence (IPV) are in some respects distinct, and some researchers have resisted collapsing the two topics, because then marital rape becomes subsumed under domestic violence and neglected, and because some men rape their partners but do not otherwise physically abuse them. At the same time, the accumulation of national data on IPV, as well as data on IPV in specific populations, and the increased sophistication of measurement of sexual assault within those studies, offers a rich source of information that has been inadequately utilized until recently.

For adult women, the highest risk of rape comes from an intimate partner. In reports from London, Guadalajara, Lima, and Zimbabwe, 23 to 25% of women reported having experienced rape or attempted rape by a partner in their lifetime (WHO, 2002). A Canadian study found that 30% of women who were raped in adulthood were assaulted by their intimate partners (Randall & Haskell, 1995). Mahoney, Williams, and West (2001) estimate that 7 million American women have been raped by intimate partners. In the United States, for 46% of women who have experienced rape or attempted rape, the perpetrator was a spouse or ex-spouse, a current or former cohabiting partner, a boyfriend or girlfriend, or—broadening the category beyond intimate partners—a date, with over half of these rapes committed by a current or former spouse or cohabiting partner (Tjaden & Thoennes, 2000). For men who have experienced rape or attempted rape, only 11% of the perpetrators fell into these categories.

Most of these intimate partner assaults of women occurred during the relationship (69%); 25% occurred both during the relationship and after the relationship ended (Tjaden & Thoennes, 2000).

Research indicates that batterers who also rape their partners are likely to be more violent and dangerous (Browne, 1987) and that rape as a component of IPV is more likely to include anal and oral intercourse than rape by acquaintances or strangers. Rape in an intimate relationship is also likely to be a repeated assault, up to 20 times or more. Financial dependence and dependence on the rapist for legal residency in the United States can make it difficult for victims of rape in marriage to escape the abuse (Russell, 1990). The NVAWS found that women were equally likely to report the rape if it was committed by an intimate partner as if it was committed by someone else. Interestingly, the police were actually more likely to refer the case for prosecution if the alleged offender was an intimate partner. However, the defendant was less likely to be prosecuted and convicted of rape if he was a former intimate partner (Tjaden & Thoennes, 2000).

Rape in Prisons

In 1973, Stephen Donaldson, a Quaker peace activist, was arrested for trespassing after a pray-in at the White House. In the course of Donaldson's two nights behind bars, he was gang-raped approximately 60 times by other inmates (Man & Cronan, 2002). Upon his release, Donaldson was one of the first survivors of prisoner rape to publicize his own abuse (Man & Cronan, 2002) and became president of Stop Prisoner Rape, a nonprofit organization that seeks to end sexual violence against men, women, and youth in all forms of detention (SPR, 2006). Donaldson died in 1996 of complications relating to AIDS, which he contracted through the rapes he experienced in prison (Man & Cronan, 2002).

It is common knowledge that men may be raped in prison—the popular media make frequent reference to the likelihood that young men without protection will be raped. Aside from the perspective of a few researchers and activists, however, this problem seemed not to be regarded as a crisis that required action on a national level until Human Rights Watch released a report in 2001. This study was the most comprehensive to date, including all 50 departments of corrections in the United States (Maruschak 2001). Only 23 departments reported collecting sexual assault statistics. Most of the correctional facilities denied that sexual violence was a problem. No statewide statistics were collected (Dumond 2003). Congress subsequently passed the Prison Rape Elimination Act in 2003, which mandates gathering national statistics about the problem, the development of guidelines for states about how to address it, creation of a review panel to hold annual hearings, and grants to states to combat the problem (SPR, 2003). The DOJ has issued grants to fund collection of data.

Men represent the vast majority of criminals sentenced to prison, and it has been assumed that sexual assault was primarily an issue among male prisoners. However, women in prison are also sexually assaulted. A study of incarcerated women in three midwestern prisons found rates of sexual coercion between 6% and 27% in the facilities (Struckman-Johnson & Struckman-Johnson, 2002). One fifth of the incidents were classifiable as rape. Half of the perpetrators were other female inmates, and half involved one or more staff. Sexual assault rates are similar for men in prison, ranging from 14% who reported sexual victimization in a study of a medium security prison (Wooden & Parker, 1982), to 21% who reported sexual pressure or assault in a study of 1,778 inmates in seven midwestern prisons (Struckman-Johnson & Struckman-Johnson, 2000).

Sexual assaults in prison differ from those outside prison in frequency and severity of assaults. Incarcerated victims are more often physically attacked during an assault than sexual assault victims outside of prison (Struckman-Johnson & Struckman-Johnson, 2000, 2002). Prisoners who have been sexually assaulted report an average of nine sexual assaults during their incarceration. Repeated abuse in prison results in feelings of helplessness and terror, trauma symptoms (Dumond, 2000, 1992; Herman, 1992a), and increased risk of suicide (Struckman-Johnson & Struckman-Johnson, 2002) and of contracting HIV (Maruschak, 2001). It is difficult for inmates to report sexual assaults because of repercussions, such as retaliation and further abuse (Dumond, 2000).

Prior Abuse

Extremely high rates of childhood physical and sexual abuse and sexual abuse in adulthood among incarcerated women suggest a causal relationship between abuse and criminality. There may be related factors such as leaving home at an early age, prostitution, substance abuse, and associating with delinquent youth and violent men that are significantly more frequent among child sexual abuse survivors. Browne, Miller, and Maguin (1999) examined abuse in the lives of female inmates in a maximum security setting in New York and found that 59% reported being sexually victimized in their childhood or adolescence. Similarly, in a recent study utilizing a random sample of 100 men incarcerated in a county jail, 59% reported some form of sexual abuse before the age of 15 (Johnson et al., 2005). In another study of 211 randomly selected male inmates, 40% met standard criteria for childhood sexual abuse, but almost 60% of those who met the criteria did not consider themselves to have been sexually abused (Fondacaro, Holt, & Powell, 1999).

RESEARCH, POLICY, AND PRACTICE DIRECTIONS

Following a public health model, which attempts first to understand the scope of the problem, we have a good idea of when, how, and by whom sexual violence is committed against girls and women and, to a lesser extent, against boys and men. We are also gaining solid information about the scope of sexual revictimization. More research needs to focus on hard-to-reach populations such as child prostitutes; children involved in pornography and sex tourism; homeless, runaway, and throwaway youth; and adults and children forced into sex trafficking.

The second goal of the public health model is to determine the risk and protective factors associated with different forms of sexual violence. We have good understanding of the risk factors associated with acquaintance rape, sexual assault of homeless youth, and revictimization of sexual abuse survivors. We are beginning to understand the possible risk factors associated with prison rape and prostitution. However, more research is needed on the risk factors for childhood sexual abuse, commercial sexual exploitation of children, and sex trafficking. The research on protective factors and resilience need more attention from mainstream researchers and service providers. In the areas of sex trafficking and commercial sexual exploitation of children, the great problem is to understand and therefore address the demand factors.

The third cornerstone of the public health model is developing and testing prevention and avoidance strategies. This aspect is by far the weakest component of our knowledge of sexual victimization. Interventions have been developed to help young women avoid sexual assault, especially college students, and these interventions appear to be somewhat effective, but they have not been effective with the most vulnerable—survivors of childhood and adolescent sexual assault, with a single

exception (Marx Calhoun, Wilson, & Meyerson, 2001). Prevention work with offenders and potential offenders has not found great success, either. A major problem in this regard, given that most sexual assaults are committed by acquaintances and go unreported, is that the great majority of offenders have not been identified and therefore cannot be targeted. Similarly, we have not learned how to reduce the demand for child pornography, child prostitution, and sex tourism, except by enhancing the criminal justice response.

In contrast, there are programs and policies in place to reduce child sexual victimization and to offer early intervention, however. The early interventions for child sexual abuse are critical because of the increased lifelong risk of revictimization among child sexual abuse survivors and the increased rate of perpetration of sexual assault and pedophilia among male child sexual abuse survivors (Lisak, Hopper, & Song, 1996). As Lisak et al. note, most men who have experienced childhood sexual abuse do not become perpetrators, but most perpetrators (70% in their sample of 126 survivors) were sexually abused. Emotional constriction and rigid gender roles were the primary predictors of which survivors would become offenders. There are also programs and policies in place to facilitate and support reporting of sexual assaults of adults and initiatives to address sex trafficking and facilitate prosecution of traffickers. Some of these more developed initiatives are described in the following segment.

Rape Crisis Programs

Rape crisis programs are the longest-standing community based interventions for sexual assault. They are included here because, despite their longevity, they have only recently been evaluated: There was an assumption that they were unquestionably good and helpful. Rape crisis programs have

evolved and become institutionalized, from their roots in the 1970s when volunteer activists received training on the crisis response and were on call to come to the side of a rape victim wherever she was. As there were few women police officers when this movement was born, the police sometimes contacted the advocates to come talk to and comfort a rape victim. Now there are more than 1,200 rape crisis programs in the United States (Campbell, 2006). Volunteers still usually staff them and provide on-call crisis intervention, medical, and legal advocacy, but now there is usually an institutional sponsor, such as a battered women's agency or hospital-based crime victims counseling program. The advocates are called to hospitals when a patient reporting a sexual assault presents herself or himself to an emergency department.

In advocating on behalf of the survivors for service delivery and to prevent secondary victimization, advocates can easily run into conflict with service providers and especially with law enforcement. Detectives called to hospitals to investigate alleged sexual assaults sometimes view advocates as an impediment to investigation. A recent evaluation by Rebecca Campbell that interviewed victims and reviewed records, however, found that survivors who had the assistance of an advocate were more likely to have police reports taken and were less likely to be treated negatively by police officers (Campbell, 2006). Survivors accompanied by an advocate during their emergency department care received more medical services, including emergency contraception and sexually transmitted disease prophylaxis, and reported significantly fewer negative interpersonal interactions with medical personnel than survivors who did not have an advocate (Campbell, 2006). Furthermore, survivors reported less distress from their emergency department visit when they had an advocate present (Campbell, 2006).

Sexual Assault Forensic Examiner Programs

Sexual Assault Forensic Examiner, or SAFE, programs are a more recent innovation than rape crisis programs, but emanate from the same philosophy and have also become established throughout the United States and other countries. Victim advocates began to develop local, state, and national reforms to address victim-blaming attitudes and substandard care experienced by women and men when seeking medical attention for a sexual assault. SAFE programs—also called Sexual Assault Nurse Examiner (SANE) programs—provide specially trained forensic nurses and doctors who can provide 24-hour first response medical care and crisis intervention to sexual assault survivors in the hospital setting (Campbell, Patterson, & Lichty, 2005).

SAFEs are trained in forensic evidence collection to facilitate prosecution if survivors choose to report the crime, in legal issues that will facilitate use of medical records and expert testimony in prosecution, and in physical, biological, and psychological consequences of sexual assault. Only recently has the effectiveness of specially trained medical providers been evaluated. Preliminary evidence shows that SAFE programs are possibly effective in all five of these domains (Campbell et al., 2005); however, more rigorous studies are needed.

Child Advocacy Centers

When a child is sexually abused and there is interest in prosecuting the case, multiple agencies become involved, and each needs to conduct an interview and/or an exam with the child. The police are generally the first to become involved, followed by detectives from special victims units and prosecutors; child protective services must be brought in; then there are doctors who conduct a forensic exam, possibly using equipment specially

designed for gynecological exams of infants and children; and psychologists, who may use dolls and drawings to find out what happened to the child.

A study conducted by Safe Horizon (Victim Services, 1994) found that sexually abused children had interviews about the abuse with eight different people on average and often had multiple interviews with each person. These interviews were conducted at many locations, including police precincts, hospitals, courts, and agency offices. Medical exams typically took place in emergency units and were often conducted by physicians with no special training in sexual exams of children. Child protective service agents tended to treat the parent who brought the child in as neglectful and, if the offender lived in the home, to place the child in foster care rather than having the police remove the offender, compounding the trauma. There was no immediate access to psychological treatment for the child.

To avoid multiple interviews with multiple strangers and to support the child and other family members, there has been a national movement to create child advocacy centers. A primary goal of the child advocacy center (CAC) is to reduce the number of interviews by videotaping sessions that can then be viewed by other professionals. A second objective is to colocate prosecutors, police, doctors, and counselors. Colocation allows different exams and interviews to be conducted at one location, requiring fewer appointments and less waiting, as well as better case coordination and information sharing. The third element is to provide a case manager who stays with the child throughout the process, providing a constant presence for the child and a resource for a nonoffending parent. CACs provide supportive counseling and support groups for the child victim as well as siblings and the nonoffending parent. The case manager can help the child become familiar with the courtroom

to ease children's fears and confusion about testifying.

CACs can be expensive and difficult to set up, requiring a dedicated child-friendly space; trained staff from multiple agencies (police, prosecution, child protection, medical, and psychiatric) who can dedicate specific hours to the CAC weekly; and core staff who can provide counseling, advocacy, and case management. A national evaluation of CACs to determine whether they actually produce the intended benefits has been conducted by the University of New Hampshire's Center for Research on Children and Crime; unfortunately, results of this evaluation have not yet been made public at the time of this publication.

Combating Commercial Sexual Exploitation of Children

There are new federal initiatives in New York City and Atlanta sponsored by OJJDP, particularly focusing on prostitution of runaway and throwaway children. There are distinct barriers to working effectively with this older juvenile population. The first problem is that they are often treated as offenders rather than victims and are arrested for prostitution or loitering. If they are returned home, they often run away again or their homes are unsafe, and there are few facilities designed specifically for their needs. If they are treated as victims rather than offenders and are placed in group homes, foster care, or other nonsecure residences, they may also run away again. They may be loyal to their pimps who are often boyfriends.

New York City, a destination for runaway and throwaway children from surrounding states, illustrates the obstacles and the programs. In the city, 150 children under 17 were arrested for prostitution in 2004 (Lowe, 2005). The center of trafficking and child prostitution is the borough of Queens, which is the focus of the CSEC initiative. From 2000 to 2004, 70 children under 17 were

arrested for prostitution in Queens, and 35 pimps were prosecuted for prostituting children under 17. The initiative includes a residential facility for girls, psychological counseling, and medical treatment. The goal of the intervention is not only to save the children but also to free them from dominance of and dependence on their pimps so that they will cooperate with prosecution.

On the international level, 32 countries have adopted laws that allow them to prosecute sex tourism committed by citizens outside their own territory (ECPAT, 2006). In the United States, Congress passed the PROTECT Act (Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today) in 2003, specifically to combat sex tourism and commercial sexual exploitation of children, as well as to strengthen federal statutes against child abuse, kidnapping, and torture. The PROTECT Act allows the United States to prosecute domestically Americans who travel outside the country for sex tourism and increases the penalties for sex tourism to 30 years in prison. It also supports programs in the State Department and the Department of Homeland Security to increase public awareness and facilitate prosecution.

Antitrafficking Legal Initiatives and Services

The U.S. DOJ, including the Office for Victims of Crime, and the Department of Health and Human Services fund programs to provide social services to victims of trafficking, with a major goal of ensuring that the victims are available and able to assist with prosecution of traffickers. Beginning in 2000, Congress enacted the Trafficking Victims Protection Act (TVPA), which creates stiff penalties for trafficking, allocates funding for the prosecution of trafficking cases and for protecting victims, and requires the State Department to issue an annual trafficking

report. It also grants special legal status to trafficking victims from other countries through the T-visa, which allows trafficking victims to stay in the United States for three years and then apply for legal permanent status. In 2002, the president created a cabinet-level Interagency Task Force on trafficking headed by the State Department's Office to Monitor and Combat Trafficking in Persons.

Antitrafficking organizations have sprung up in the United States and in many other countries. Existing immigration, antislavery, and victim assistance programs have tailored their services for trafficking victims, most serving victims of all forms of trafficking, but some specializing in particular forms of exploitation, including sex trafficking. Like other trafficking victims, those who have escaped from sex trafficking usually need psychological treatment for trauma, housing, and a source of income. They also need support in testifying against their traffickers and legal assistance in applying for a T-visa. There are regional, national, and international coalitions of service providers. In the United States, these include the California-based organization Coalition to Abolish Slavery and Trafficking, the national Freedom Network, and the midwestern Heartland Alliance. CAT-W is an international coalition of organizations focusing solely on sex trafficking, with representation in Africa, the Philippines, and Asia. In Asia, member organizations have projects to rehabilitate girls and women forced into prostitution, providing them with education, training, and employment.

REFERENCES

- Bazon, E. (2006, April 30). A question of resilience. *The New York Times Magazine*, pp. 54-59.
- Boney-McCoy, S., & Finkelhor, D. (1995). Psychosocial sequelae of violent victimization in a national youth sample. *Journal of Consulting and Clinical Psychology*, 63(5), 726-736.

- Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child sexual abuse histories. *Child Abuse & Neglect*, 14, 357-364.
- Browne, A. (1987). *When battered women kill*. New York: Free Press.
- Browne, A., Miller, B., & Maguin, E. (1999). Prevalence and severity of lifetime physical and sexual victimization among incarcerated women. *International Journal of Law and Psychiatry*, 22(3), 301-323.
- Caceres, C. F., Vanoss, M., & Hudes, E. S. (2000). Sexual coercion among youth and young adolescents in Lima, Peru. *Journal of Adolescent Health*, 27, 361-367.
- Campbell, R. (2005). What really happened? A validation study of rape survivors' help-seeking experiences with legal and medical systems. *Violence and Victims*, 20(1), 55-68.
- Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women*, 12(1), 30-45.
- Campbell, R., Patterson, D., & Lichty, L. F. (2005). The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: A review of psychological, medical, legal, and community outcomes. *Trauma, Violence & Abuse*, 6(4), 313-329.
- Campbell, R., & Raja, S. (1999). The secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims*, 14, 261-275.
- Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape": Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence*, 16, 1239-1259.
- Catalano, S. M. (2005). *Criminal victimization 2004*. National crime victimization survey (NCJ 210674). Washington, DC: Bureau of Justice Statistics.
- Cohen, Y., Spirito, A., & Brown, L. K. (1996). Suicide and suicidal behavior. In R. J. Declemente, W. B. Hanson, & L. E. Ponton (Eds.), *Handbook of adolescent health risk behavior* (pp. 193-224). New York: Plenum Press.
- Cusick, L., Martin, A., & Tiggey, M. (2003). *Vulnerability and involvement in drug use and sex work*. London: Great Britain Home Office Research Development and Statistics Directorate.
- DeWeese, J. (2004, November 26). "Feds arrest six in Corona human trafficking ring." *Times-Ledger Newspapers*. Retrieved April 15, 2006, from <http://safehorizon.org/page.php?page=inthe%20newsdebil&rcid=72>
- Dumond, R. W. (1992). The sexual assault of male inmates in incarcerated settings. *International Journal of Sociology*, 20, 135-157.
- Dumond, R. W. (2000). Inmate sexual assault: The plague which persists. *Prison Journal*, 80, 407-414.
- Dumond, R. W. (2003). Confronting America's most ignored crime problem: The Prison Rape Elimination Act of 2003. *Journal of the American Academy of Psychiatry Law*, 31, 354-360.
- Economic and Social Commission for Asia and the Pacific (ESCAP). (2000). *Sexually abused and sexually exploited children and youth in the greater Mekong subregion: A qualitative assessment of their health needs and available services*. Geneva, Switzerland: United Nations.
- ECPAT. (1996). *The Paedo file*. ECPAT Newsletter, 4(4).
- ECPAT. (2006). Commercial sexual exploitation of children in the United States. Retrieved January 10, 2006, from www.ecpat.net/eng/Ecpat_inter/projects/monitoring/online_data_base/index.asp
- Ensign, J., & Santelli, J. (1998). Health status and service use: Comparison of adolescents at a school-based health clinic with homeless adolescents. *Archives of Pediatrics and Adolescent Medicine*, 152(1), 20-24.
- Estes, R. J., & Weiner, N. A. (2001). The commercial sexual exploitation of children in the U.S., Canada and Mexico. Philadelphia: University of Pennsylvania. Retrieved March 2, 2006, from www.sp2.upenn.edu/%7Erestes/CSEC.htm
- The Facts About Child Sex Tourism*. (2005, April 14). Washington, DC: U.S. State Department, Department of Homeland Security.
- Farley, M. (2003). Prostitution and trafficking in nine countries: An update on violence and posttraumatic stress disorder. *Journal of Trauma Practice*, 2(3/4), 33-74.

- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *Journal of Orthopsychiatry*, 55(4), 530–541.
- Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse & Neglect*, 14(1), 19–28.
- Fisher, B. S., Cullen, F. T., & Turner, M. G. (2000). *The sexual victimization of college women* (NCJ 182369). United States Department of Justice. Washington, DC: U.S. Government Printing Office.
- Fondacaro, K. M., Holt, J. C., & Powell, T. A. (1999). Psychological impact of childhood sexual abuse on male inmates: The importance of perception. *Child Abuse and Neglect*, 23(4), 361–369.
- Greene, J. M., Ennett, S. T., & Ringwalt, C. L. (1999). Prevalence and correlates of survival sex among runaway and homeless youth. *American Journal of Public Health*, 89, 1406–1409.
- Halcón, L., Beuhring, T., & Blum, R. (2000). *A portrait of adolescent health in the Caribbean, 2000*. Minneapolis: University of Minnesota and the Pan American Health Association.
- Harner, H. (2000, April). *Sexual violence and adolescents*. Applied Research Forum: National Online Resource Center on Violence Against Women. Available at www.vawnet.org/SexualViolence/Research/VAWnetDocuments/AR_Adolescent.pdf
- Herman, J. L. (1981). *Father-daughter incest*. Boston: Harvard University Press.
- Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5, 377–391.
- Herman, J. L. (1992b). *Trauma and recovery*. New York: Basic Books/HarperCollins.
- Hughes, D., & Roche, C. (Eds.). (1999). *Making the harm visible: Global sexual exploitation of women and girls*. Kingston, RI: Coalition Against Trafficking in Women.
- Johnson, R. J., Ross, M. W., Taylor, W. C., Williams, M. L., Carvajal, R. I., & Peters, R. J. (2005). A history of drug use and childhood sexual abuse among incarcerated males in a county jail. *Substance Use and Misuse*, 40(2), 211–229.
- Kerry, Isakson Push for Tougher Penalties for Child Internet Pornography. (2005, December 20). Press release. Congress of the United States, Washington, DC 20515.
- Kipke, M. D., Simon, T. R., Montgomery, S. B., Unger, J. B., & Iversen, E. F. (1997). Homeless youth and their exposure to and involvement in violence while living on the streets. *Journal of Adolescent Health*, 20, 360–367.
- Klain, E. J. (1999). *Prostitution of children and child-sex tourism: An analysis of domestic and international responses*. Alexandria, VA: Center for Missing and Exploited Children.
- Kral, A. H., Molnar, B. E., Booth, R. E., & Waters, J. K. (1997). Prevalence of sexual risk behavior and substance use among runaway and homeless adolescents in San Francisco, Denver and New York City. *International Journal of STD & AIDS*, 8, 109–117.
- Kurtz, S. P., Surratt, H. L., Inciardi, J. A., & Kiley, M. C. (2004). Sex work and “date” violence. *Violence Against Women*, 10(4), 357–385.
- Lisak, D., Hopper, J., & Song, P. (1996). Factors in the cycle of violence: Gender rigidity and emotional constriction. *Journal of Traumatic Stress*, 9, 721–743.
- Lowe, H. (2005, June 21). Operation guardian: Child prostitution project in Queens. *Newsday*, p. A7.
- Mahoney, P., Williams, L. M., & West, C. M. (2001). Violence against women by intimate partner relationships. In C. Renzetti, J. Edleson, & R. Bergen (Eds.), *Sourcebook on violence against women* (pp. 143–178). Thousand Oaks, CA: Sage Publications.
- Man, C. D., & Cronan, J. P. (2002). Forecasting sexual abuse in prison: The prison subculture of masculinity as a backdrop for “deliberate indifference.” *Journal of Criminal Law and Criminology*, 92(127), 1–38.
- Maruschak, L. M. (2001). HIV in prisons and jails, 1999 (NCJ 187456). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Marx, B. P., Calhoun, K. S., Wilson, A. E., & Meyerson, L. A. (2001). Sexual revictimization prevention: An outcome evaluation. *Journal of Consulting and Clinical Psychology*, 69(1), 25–32.

- Masha's story*. (2006). Web site set up by Masha Allen's attorney, James R. Marsh. Retrieved May 5, 2006, from www.mashastory.info/
- Masson, G. (1984). *The assault on truth: Freud's suppression of the seduction theory*. New York: Farrar, Straus, Giroux.
- McClanahan, S. F., McClanahan, G. M., Abram, K. M., & Teplin, L. A. (1999). Pathways into prostitution among female jail detainees and their implications for mental health services. *Psychiatric Services*, 50, 1606–1613.
- Ministry of Foreign Affairs of Japan (MOFA). (2001, December 17–20). *Report of the Second World Congress Against Commercial Sexual Exploitation of Children*. Yokohama, Japan.
- Molnar, B. E., Shade, S. B., Kral, A. H., Booth, R. E., & Watters, J. K. (1998). Suicidal behavior and sexual/physical abuse among street youth. *Child Abuse & Neglect*, 22(3), 213–222.
- Musa, J. N. (2006, February 7). 25 NGOs fight human trafficking. *Daily Trust (Ajuba)*. Retrieved May 9, 2006, from <http://allafrica.com/stories/200602070363>
- National Center for Missing and Exploited Children. (2002). *Female juvenile prostitution: Problem and response* (2nd Ed.). Retrieved February 15, 2006, from www.missingkids.com/missingkids/servlet/ResourceServlet?LanguageCountry=en_US&PageId=750
- Noell, J., Rohde, P., Seeley, J., & Ochs, L. (2001). Childhood sexual abuse, adolescent sexual coercion, and sexually transmitted infection acquisition among homeless female adolescents. *Child Abuse & Neglect*, 25(1), 137–148.
- Randall, M., & Haskell, L. (1995). Sexual violence in women's lives: Findings from the Women's Safety Project, a community-based survey. *Violence Against Women*, 1(1), 6–31.
- Rennison, C. (2002). *Criminal victimization, 2001: Changes 2000–01 with trends, 1993–2001*. National crime victimization survey (NCJ 194610). Washington, DC: Bureau of Justice Statistics.
- Rew, L., Taylor-SeeHafer, M., & Fitzgerald, M. L. (2001). Sexual abuse, alcohol and other drug use, and suicidal behaviors in homeless adolescents. *Issues in Comprehensive Pediatric Nursing*, 24, 225–240.
- Rotheram-Borus, M. J., Mahler, K. A., Koopman, C., & Langabeer, K. (1996). Sexual abuse history and associated multiple risk behavior in adolescent runaways. *American Journal of Orthopsychiatry*, 66, 390–400.
- Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.
- Russell, D. E. H. (1990). *Rape in marriage*. New York: Macmillan.
- Ryan, K. D., Kilmer, R. P., Cauce, A. M., Watanabe, H., & Hoyt, D. R. (2000). Psychological consequences of child maltreatment in homeless adolescents: Untangling the unique effects of maltreatment and family environment. *Child Abuse & Neglect*, 24, 333–352.
- Silverman, J. G., Raj, A., Mucci, L. A., & Hathaway, J. E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy and suicidality. *JAMA*, 286(5), 572–579.
- Snyder, H. N. (2000). Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics (NCJ 182990). Pittsburgh, PA: National Center for Juvenile Justice.
- Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability* [Special Issue]. *Sexual Exploitation of People with Disabilities*, 9, 243–259.
- Stop Prisoner Rape (SPR). (2003). Press release: Prison Rape Elimination Act becomes federal law. Retrieved March 3, 2006, from www.spr.org/en/pressreleases/2003/0904.html
- Stop Prisoner Rape (SPR). (2006). Stop prisoner rape: A brief history. Retrieved on March 3, 2006, from www.spr.org/en/spr_history.asp
- Struckman-Johnson, C. J., & Struckman-Johnson, D. L. (2000). Sexual coercion rates in seven midwestern prison facilities for men. *Prison Journal*, 80, 379–390.
- Struckman-Johnson, C. J., & Struckman-Johnson, D. L. (2002). Sexual coercion reported by women in three midwestern prisons. *Journal of Sex Research*, 39(3), 217–228.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the national violence against*

- women survey (NCJ 181867). Washington, DC: National Institute of Justice.
- Tjaden, P., & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the national violence against women survey* (NCJ 210346). Washington, DC: National Institute of Justice.
- Tyler, K. A., & Cauce, A. M. (2002). Perpetrators of early physical and sexual abuse among homeless and runaway adolescents. *Child Abuse & Neglect*, 26, 1261–1274.
- Tyler, K. A., Whitbeck, L. B., Hoyt, D. R., & Cauce, A. M. (2004). Risk factors for sexual victimization among male and female homeless and runaway youth. *Journal of Interpersonal Violence*, 19(5), 503–520.
- United Nations Economic and Social Council, Commission on Human Rights. (1996). *Report of the special rapporteur on the sale of children, child prostitution, and child pornography*. 52nd sess., agenda item 20. UN doc E/CN.4/1996/100. Retrieved March 20, 2006, from www.unhchr.ch/children/rapporteur.htm
- United Nations. (2006). Youth at the United Nations: Frequently asked questions. Retrieved March 5, 2006, from www.un.org/esa/socdev/unyin/qanda.htm
- United States Embassy Stockholm (USES). (1996, August 27–31). *Child pornography: An international perspective*. World Congress Against the Commercial Sexual Exploitation of Children, Stockholm, Sweden.
- Victim Services. (1994, July). *Child sexual abuse public policy project and multidisciplinary response protocol: Executive summary*. New York: Victim Services (now Safe Horizon).
- Wikipedia. (2006). Entry for *Masha Allen*, “Masha’s Law.” Retrieved May 6, 2006, from http://en.wikipedia.org/wiki/Masha_Allen
- Willis, B. M., & Levy, B. S. (2002). Child prostitution: Global health burden, research needs and interventions. *Lancet*, 359(9315), 1417–1422.
- Wooden, W. S., & Parker, J. (1982). *Men behind bars: Sexual exploitation in prison*. New York: Plenum.
- World Health Organization. (2002). *World report on violence and health*, E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.). Geneva: World Health Organization.
- World Health Organization. (2005). *Summary report: WHO multi-country study on women’s health and domestic violence against women*. Geneva: World Health Organization.

Publication 2

Fry, D.A., Davidson, L.L., Rickert, V.I. and H. Lessel (2008). *Partners and Peers: Sexual and Dating Violence Among NYC Youth*. A Research Report by the NYC Alliance against Sexual Assault in Conjunction with the Columbia University Centre for Youth Violence Prevention. New York City Alliance Against Sexual Assault: New York.

Copyright permission obtained from the NYC Alliance Against Sexual Assault and the co-authors of this publication to use and archive this research report within this PhD by Publications thesis.

Partners and Peers: Sexual and Dating Violence Among NYC Youth

A Research Report by the
New York City Alliance Against Sexual Assault
and the Columbia Center for Youth Violence Prevention,
Columbia University

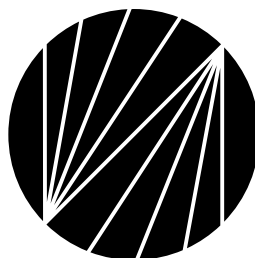


Partners and Peers: Sexual and Dating Violence Among NYC Youth

**A Research Report by the
New York City Alliance Against Sexual Assault
and the Columbia Center for Youth Violence Prevention,
Columbia University**

***By Deborah A. Fry, Leslie L. Davidson,
Vaughn I. Rickert, and Harriet Lessel***

*With assistance from Daisy Deomampo,
Niki Palmetto, Mónica G. Paz,
and Saroj Sedalia*



**New York City Alliance
Against Sexual Assault**

Published by the
New York City Alliance Against Sexual Assault

27 Christopher Street, Third Floor
New York, NY 10014
Phone: 212.229.0345
Fax: 212.229.0676
research@nycagainstrape.org
www.nycagainstrape.org

First printing: June 2008
Cover and design: Scott Santoro/Worksight
Editor: Stacie Joy

This report on the study findings was supported in part by the cooperative agreement number 5 U49 CE000731 from the Centers for Disease Control and Prevention (CDC). Its contents are the sole responsibility of the authors and do not necessarily represent the official views of the CDC.

This report on the study findings was supported in part by the New York City Council. Its contents are the sole responsibility of the authors and do not necessarily represent the official views of the New York City Council.

Copyright © 2008
New York City Alliance Against Sexual Assault
All rights reserved
Printed in the United States

Table of Contents

Foreword from the NYC Alliance Against Sexual Assault	7	Figures	
Foreword from the Columbia Center for Youth Violence Prevention	8	Figure 1: Age Distribution of Sample Compared with NYC Data	22
Acknowledgments	9	Figure 2: Overlap between Nonpartner and Partner Sexual Violence Victimization	26
About the Authors	11	Figure 3: Reported Experiences of Nonpartner Sexual Violence	27
Executive Summary	13	Figure 4: Percentage of Youth that Report Ever Experiencing Physical Dating Violence	36
Chapter 1: Introduction	19	Figure 5: Youth Self-Reporting Behavior and Experiences of Dating Violence	36
Chapter 2: Nonpartner Sexual Violence	25	Figure 6: Percentage of Youth Who Report Experiencing Physically Violent Behaviors in Their Current Dating Relationship	37
Chapter 3: Dating Violence	33	Figure 7: Percentage of Youth Who Report Experiencing Sexually Violent Behaviors in Their Current Dating Relationship	40
Chapter 4: Intersections of Violence	47	Figure 8: Percentage of Youth Who Report Sexually Coercive Behavior with Condom Use	44
Chapter 5: The Impact of Sexual and Dating Violence on Health	55	Figure 9: Comparison of NYC YRBS 2007 Data and Study Sample on Violence Indicators	48
Chapter 6: From Research to Action	65	Figure 10: Health Outcomes of Partner Violence/Sexual Violence/Child Sexual Abuse	56
Appendix A: Methodology	75	Figure 11: Person Youth First Tell about Their Experiences with Dating Violence	61
Appendix B: Survey Instrument	82	Figure 12: Youth Dating Violence Disclosure	62
References	100	Figure 13: NYC Alliance Against Sexual Assault Violence Prevention Framework	67

Table of Contents (continued)

Tables

Table 1:	Prevalence of Sexual Violence among Youth in NYC: Selected Studies 1997–2007	21
Table 2:	Youth Self-Reported Frequency of Physical Dating Violence Victimization and Perpetration within the Past Year	38
Table 3:	Youth Self-Reported Frequency of Sexual Dating Violence Victimization and Perpetration within the Past Year	41
Table 4:	Controlling Behaviors Experienced by Youth	42
Table 5:	Physical Dating Violence Victimization and Other Violence	49
Table 6:	Sexual Dating Violence Victimization and Other Violence	50
Table 7:	Physical Dating Violence Perpetration and Other Violence	51
Table 8:	Sexual Dating Violence Perpetration and Other Violence	52
Table 9:	Physical Dating Violence Victimization and Health	57
Table 10:	Sexual Dating Violence Victimization and Health	57
Table 11:	Physical Dating Violence Perpetration and Health	59
Table 12:	Sexual Dating Violence Perpetration and Health	59
Table 13:	Adjusted Odds Ratios (95% Confidence Intervals) of Functional Health Status Indicators	60
Table 14:	Overview of Recommendations by Key Findings	73
Table 15:	Sample Distribution	77

Youth Voices

Youth Voices: How Has Sexual Violence Affected You?	29
Youth Voices: How Has Dating Violence Affected You?	39
Marie’s Story	43
Youth Voices: What Should Schools Do to Reduce or Prevent Sexual or Dating Violence?	68
Youth Voices: What Do You Think Would Reduce Sexual or Dating Violence in the Lives of Teens?	71

Text Boxes

Key Terms Used in this Report	19
Underreporting of Rape and Sexual Assault	28
Youth-Produced Documentary: <i>It’s Not about Sex</i>	31
Theories of Teen Dating Violence	34
The Social Ecological Model	66
Youth Action Council	70
NYC Teen Health Map	72

Foreword from the NYC Alliance Against Sexual Assault

The NYC Alliance Against Sexual Assault is proud to release its groundbreaking study *Partners and Peers: Sexual and Dating Violence among NYC Youth*, providing NYC-specific information on high school age youth's experiences with sexual and dating violence. *Partners and Peers* surveyed boys and girls in a school-based setting and asked extensive questions about help-seeking behaviors.

In a time of limited resources, the Alliance wants to ensure that efforts target those most in need. Current national and local research reveals that adolescents are more likely to experience sexually violent crimes than any other age group. Building upon these studies and utilizing validated scales, *Partners and Peers* fills a gap in the local information that is required to determine the most effective response.

Partners and Peers found that youth tell other youth—if they tell anyone at all—about their experiences. This makes it essential that information is available to teens in a format they can utilize. The Teen Health Map, with a subway map on one side and youth-friendly referral guide to health and sexual violence resources on the other, was developed by the Alliance to support those who participated in the study. This has become an important resource on its own as a confidential source of information that youth can share with each other. In its second printing, the map has been purchased by the NYC Department of Education and Department of Youth and Community Development for those they serve. The Teen Health Map was tested extensively and developed to young people's specifications for use and confidentiality.

The Alliance was fortunate to have fantastic project partners, and wishes to thank the NYC Council for its interest and funding of the project. *Partners and Peers* was jointly conducted with the Centers for Disease Control and Prevention-funded Columbia Center for Youth Violence Prevention. Dr. Leslie Davidson and Dr. Vaughn Rickert from that center are inspiring to work with, especially in their interest in how research can be used in real-life settings to effect change. The four school principals that considered sexual and dating violence an important enough problem to participate in the study are wonderful examples of leaders interested in school-community partnerships. Many thanks go out to them and the NYC Department of Education.

The findings of *Partners and Peers* reveal the urgent need to address the risk factors for experiencing sexual violence, to understand the health and psychosocial implications of victimization, and to increase resources for preventing violence among NYC youth. Due to their increased vulnerability, youth remain a priority for the Alliance's programming. The Alliance looks forward to working with various partners in the public and private sector to join in making a difference in the lives of New York City's young people.



Harriet Lessel, Executive Director
New York City Alliance Against Sexual Assault

Foreword from the Columbia Center for Youth Violence Prevention

Violence and coercion are not isolated phenomena in the lives of young people. Often when people speak of youth violence, they mean gang violence. It is clear from this report about adolescents in New York City, and from other research around the country, violent behavior and coercion characterize many early romantic and sexual relationships among young people. The Columbia Center for Youth Violence Prevention (the CCYVP) is grateful for the opportunity to work with the superb leaders and researchers (Deborah Fry and Harriet Lessel) at the NYC Alliance Against Sexual Assault to plan and carry out this study. The CCYVP wishes to thank the students, parents, teachers, and principals, without whom nothing would have been learned.

Partners and Peers begins to delineate some of the patterns found in the violence involving young people. It is extremely common and affects all genders, both those who inflict violence and those who receive it, older and younger adolescents. The high school students in the study were clear in what they reported; sexual and physical dating violence often occur together and prevention efforts need to take this into account. Often both people in a relationship are engaged in coercive behavior, sometimes just one. Intimate partner violence among young people is associated with other forms of violence—with the use of weapons, gang membership, and fear. It is also related to the health status of both victims and perpetrators.

There are many questions that need further exploration in order to identify risk and protective factors. For example, the study found that young women were more likely to hit a male partner than young men were to report hitting a female partner—because the study was a survey, the degree of physical damage done or the meaning of the action itself is not known. These issues are important to understand in order to plan prevention, intervention, and care.

Acknowledging the strengths and limitations of what is known, these findings need to be shared with key stakeholders in the community of New York City—the students, parents, educators, healthcare professionals, and policymakers. Plans must be made to learn what will prevent these harmful behaviors and how to protect the young people who are experiencing them. This will involve education, research, and policy. The Columbia Center for Youth Violence Prevention looks forward to participating in these efforts.



Bruce G. Link
Director of the Columbia Center for Youth Violence Prevention
Columbia University

Acknowledgements

This study was conducted by the research department at the New York City Alliance Against Sexual Assault (the Alliance), led by Deborah Fry, and the Columbia Center for Youth Violence Prevention (the CCYVP) at the Mailman School of Public Health, by Principal Investigator Dr. Leslie Davidson and Coinvestigator, Dr. Vaughn Rickert.

The study would like to thank all participating youth for sharing their thoughts and experiences so work can begin to end sexual and dating violence. The study would also like to thank the youth who assisted in developing and piloting the survey questionnaire: their input made a difference and was much appreciated. Additional thanks go to the wonderful parents, more than 90% of whom recognized the importance of this work and permitted their children to participate.

Special thanks goes to the research associates and assistants who helped collect data in the schools, monitored the data entry, and worked on developing this comprehensive report: Daisy Deomampo, Niki Palmetto, Mónica G. Paz, and Saroj Sedalia. Without their support, enthusiasm, and tireless efforts, this study would not have been possible. A big thank you goes to the data-entry volunteers, Christy Banister, Sylvan Rosas, Erin Hopkins, and Elizabeth Richards for their meticulous attention to detail and dedication to entering the survey data for the study. Gracious thanks also to the interns who helped produce this report, especially Lauren Lorek and McKenna Knych.

The study would like to thank the New York City Department of Education for recognizing the importance of studying sexual and dating violence among youth. A warm thank you goes to the four participating schools and their staff. Particular thanks go to the leadership of the school's principals and district superintendents for working with the Alliance and the CCYVP on the Institutional Review Board protocols, Department of Education approvals, and data collection process. Without

them, this project could not have succeeded. Their tireless effort to understand the experiences and improve services for youth is extraordinary.

Personal thanks go to the individuals who helped translate the survey instrument, parental consent letters, and student consent forms: Teresa Román from Portada, LLC., for the Spanish translations, and staff members from the Language Lab & Translation Company of America for the Spanish back-translations and the Chinese translations. This allowed for a bilingual study with trilingual consent forms in a multicultural city. Gratitude also goes to the stakeholders who reviewed the various survey drafts and many of whom provided input for improving this report. The study is especially grateful to Bill Bacon for programming the ACASI version of the survey and recording the voices for the computer-based survey in Spanish and English, using male and female voices.

Appreciation also goes to the 2006–2007 NYC Alliance Against Sexual Assault Research Advisory Committee for their guidance on the Alliance's research projects and their comments on this report: Larry Busching, Daisy Deomampo, Victoria Frye, Donna Gaffney, Mandi Larsen, Cari Olson, Chitra Raghavan, Catherine Stayton, Hope Wachter, and Susan Xenarios.

Extraordinary thanks goes to the following Alliance staff: Tamara Pollak, previous program director; Jenn Tierney, previous communications director; Chris St. John, community action coordinator; Deiderie Armstrong, assistant director; Tamecca Phillips, administrative assistant; as well as an extra-special thanks to Harriet Lessel, executive director, for her vision and ongoing support of this research project. Warmest thanks go to all of the Alliance's board members who commented on drafts of the report and for their leadership in supporting youth initiatives.

At Columbia University, the study wishes to thank staff and associates of the Columbia Center for Youth Violence Prevention for assistance in inter-

preting and disseminating the study findings to parents and teachers, as well as city and national communities. The following folks were particularly helpful: Monalissa Paredes, Saroj Sedalia, Peter Simon, and Mariko Geiger.

Last, a warm thank you goes to William F.B. O'Reilly and Lindsay Dussing from Nicholas & Lence Communications, LLC., who have worked with the Alliance and the CCYVP to ensure that these study findings are disseminated widely throughout New York City. Due to their support and work, the study has been able to reach many New Yorkers about the importance of addressing and responding to youth sexual and physical dating violence.

This research and publication was funded by grants from the New York City Council and the Centers for Disease Control and Prevention and the study would like to thank these two funders for their contributions to understanding youth sexual and dating violence and to developing evidence-based programs to address this violence. The opinions expressed in this report are those of its authors and do not necessarily represent the views of the New York City Council nor the Centers for Disease Control and Prevention.

About the Authors

Deborah Fry, MA, MPH is the research director at the New York City Alliance Against Sexual Assault. At the Alliance, Deborah works on citywide research projects, all geared toward helping improve service delivery for survivors in NYC and evaluating prevention and intervention programs. Current projects include *Partners and Peers: Sexual and Dating Violence Among NYC Youth* with the Columbia University Center for Youth Violence Prevention, *ARISE: Action Research for Immigrant Social Empowerment* with a coalition of six community-based organizations, *Translating Research into Practice: Best Acute Care for Sexual Assault Patients*, and evaluation of the Primary Prevention Demonstration Project in NYC. Recently completed Alliance research reports include *Bringing the Global to the Local: Using Participatory Research to Address Sexual Violence with Immigrant Communities in NYC* (2008), *A Room of Our Own: Survivors Evaluate Services* (2007), and *How S.A.F.E. Is NYC? The Services Available to Sexual Assault Patients in NYC's Emergency Departments* (2007). In addition to conducting primary research, Deborah provides technical assistance to the NYC rape crisis programs and is a volunteer rape crisis advocate with the Crime Victims Treatment Center at St. Luke's-Roosevelt Hospital. Ms. Fry has a master of arts degree from the Maxwell School of Citizenship and Public Affairs at Syracuse University, and her master of public health degree from Columbia University. Deborah was also a Fulbright Research Scholar from 2001 to 2002.

Dr. Leslie Davidson, MD, MSc, FRCP (London), FAAP is a professor of clinical epidemiology and clinical pediatrics at Columbia University's Mailman School of Public Health. She received her MD from Columbia University as well as her training in pediatrics followed by an MSc in epidemiology from the University of London's London School of Hygiene and Tropical Medicine. At Columbia, she is a member of the executive committee of the CDC-funded Columbia Center for Youth Violence Prevention and leads its Dating Violence Research program. She is also on the executive committee of the Columbia Center for Children's Environmental Health and a senior child-health advisor to the National Center for Children in Poverty. She chairs the Columbia University Head Start's Health Advisory Committee and is a member of the community advisory board of Planned Parenthood NYC. Dr. Davidson is the director

of the Center for Child and Family Life Epidemiology as well as the director of the doctoral programs in epidemiology at Columbia. She has authored more than 100 scientific publications and is a member of the editorial board of child health education and development.

Dr. Vaughn I. Rickert, Psy.D. is a professor of clinical population and family health and director of the academic program for the Heilbrunn Department of Population and Family Health at the Mailman School of Public Health at Columbia University. He received his doctorate in clinical psychology from Central Michigan University and completed his predoctoral training at Johns Hopkins University School of Medicine at the Kennedy Krieger Institute. He joined the Mailman School of Public Health in 2001 to serve as the director of the research and evaluation unit of the Center for Community Health and Education, the domestic service system of seven school-based health centers and a family-planning clinic in the Washington Heights community. Dr. Rickert has authored or coauthored more than 100 publications on adolescent health and serves on the editorial board of the *Journal of Adolescent Health*. Additionally, Dr. Rickert is a past president of the Society for Adolescent Medicine (or SAM), a multidisciplinary professional society devoted exclusively to the health and wellbeing of adolescents.

Harriet Lessel, LCSW is the first and current executive director of the New York City Alliance Against Sexual Assault. Ms. Lessel led the effort to create an organization that focused on a citywide response to intervention and prevention of sexual violence in conjunction with the City's rape-crisis programs. She has dedicated her career to supporting survivors and eradicating sexual assault through counseling, advocacy, community organizing, and public education. Prior to her work at the Alliance, Ms. Lessel's thirty years of experience includes managing the largest multiservice hospital-based rape crisis and domestic violence program in Brooklyn, opening the first Sexual Assault Examiner program (also in Brooklyn), managing youth development and senior programs, and providing direct counseling and advocacy services to at-risk teens and their families. Ms. Lessel has a master's degree in social work from Columbia University and is a licensed clinical social worker in the State of New York.

“What I know now is that if I had known I wasn’t alone, I may have been able to help him and to help myself. I usually have one message for young people who may go through something similar: You are not alone.”

—female teen dating violence survivor

Executive Summary

“I have come to understand over the past few years how prevalent of a problem teen dating violence truly is. When I look back at my own situation, I always believed that I was alone. I believed that my situation was different. I wanted to feel as if I was doing the right thing by letting myself stay in the abusive relationship. What I know now is that if I had known I wasn’t alone, I may have been able to help him and to help myself. I usually have one message for young people who may go through something similar: You are not alone.”

—female teen dating violence survivor

Sexual and dating violence is not only a crime that disproportionately affects adolescents and young adult women, it is a huge challenge for those who are responsible for the wellbeing of youth in New York City—this includes health professionals, educators, community leaders, and public officials. It is a central concern for young people themselves and for their parents.

Research has demonstrated that both male and female victims of sexual and dating violence are at greater risk for developing an array of health risk behaviors and adverse life outcomes affecting psychological, social, and physical wellbeing. Given that childhood and adolescence is a time of increasing risk and vulnerability for sexual and dating violence, as well as a time when sexual violence can have overwhelming and injurious effects, it is critical more learning and continued improvement occur, as well as a deeper understanding of how violence develops in relationships, how it is related to other negative behaviors, and how to prevent it. Assisting young people facing these problems and learning how to avoid the harmful outcomes resulting from these experiences is key.

The *Partners and Peers* study was conducted to establish baseline data on the prevalence and

nature of sexual and dating violence among young people in New York City area schools. This includes information on perpetration of sexual and dating violence, disclosure of violence, the degree of association with exposure to community violence, and the degree of mutual participation in partner violence, all with the aim of developing effective intervention and prevention programs. The study was carried out jointly by the New York City Alliance Against Sexual Assault and the Columbia Center for Youth Violence Prevention. The study partners combined resources and expertise to conduct this study and to advocate for social and systems change in New York City.

The study was conducted in four public high schools in New York City and all students were invited to participate. The New York City Department of Education granted researchers permission to enroll NYC high school students anonymously, with their parents’ consent, and their own permission with the agreement of school principals and district superintendents. Students from four schools, reflecting a range of cultural groups, were asked to participate. Schools were selected through convenience sampling, three in Manhattan and one in Brooklyn. In all, the Alliance and CCYVP surveyed 1,454 students. Of these, 64 surveys were incomplete and were eliminated due to the extensive missing data. (See, for full explanation of sampling procedure, Appendix A: Methodology on page 75.) The total sample size for the analyses presented is 1,312 youth ranging in age from 13–21. This data collection took place during the 2006–2007 school year and was approved by three Institutional Review Boards.

The Alliance is one of the few nonprofit anti-sexual-violence organizations that conducts applied research for social change. The Alliance works with city agencies, rape crisis programs, hospitals, community-based organizations, and New Yorkers to improve care for survivors and end sexual violence in New York City. The CCYVP is a collaboration of researchers, policymakers, and community

representatives committed to understanding and reducing youth violence. The CCYVP is one of 12 Academic Centers of Excellence funded by the Centers for Disease Control and Prevention. Both organizations are committed to ending sexual and dating violence *before* it occurs. The study seeks to assist youth experiencing this violence and represents the first comprehensive exploration of teen sexual and dating violence in New York City.

Partners and Peers reports on male and female adolescent perpetration and victimization in their dating relationships. The study does not in any way wish to undermine the clear and widely accepted understanding that the impact of relationship violence falls primarily on women who suffer the majority of severe forms of violence—battering, stalking, rape, and murder.

Key Findings:

Sexual and dating violence are extremely common among NYC youth. In this study, 16% (or more than one in six students) reported experiencing sexual violence at some point in their lives. Of these youth, 10% reported ever experiencing nonpartner sexual violence (sexual abuse or forced sex). Fourteen percent reported experiencing partner sexual violence (either current or past). Youth were also asked how often in their lives any (current or previous) partner had hurt them physically. Among students with a dating history, more than half (56%) reported experiencing physical dating violence. Of these youth, more than a quarter (27%) reported ever being pushed or shoved by a dating partner, and 11% said that a dating partner punched them at some point in their lives.

Dating violence is often inclusive of both physical and sexual violence. There is tremendous overlap between the various forms of dating violence. In this study, 71% of youth who experienced threatening behaviors from a dating partner also experienced physical violence from that dating partner. Likewise, 63% of youth who reported experiencing sexual violence from their partner experienced physical dating violence from that same partner.

The violence experienced by NYC youth can be serious and potentially lethal. Though much of the violence reported here involves hitting, shoving, or unwilling/unwanted sexual touching, 8% reported that a dating partner had choked them, and 3% reported that a dating partner hurt them with an object or weapon. Nine percent reported having been forced into sexual activity, and 3% reported rape.

Physical dating violence is not one-sided nor is it all males against females. Thirty-two percent of students, both males and females, reported perpetrating one or more episodes of physical violence against their partners in the past year.

Youth experience sexual violence from people they know. In this study, 89% of youth who had experienced sexual violence at some time in their lives said it was committed against them by someone they knew. Youth are experiencing this violence at the hands of people they know and trust, such as their dating partners, family members, and other acquaintances.

Many young people do not feel that being hit, shoved, or forced into sexual behavior is “abuse” or “violence.” Only 20% of youth who had experienced physically or sexually violent behaviors from a dating partner said yes when asked if they had experienced “physical or sexual violence.”

Youth tell their friends first, though about 40% never told anyone. More than half (59%) of youth who reported they had experienced sexual or dating violence had told someone about their experiences. Youth are most likely to tell their friends *first*. Overall, 88% of youth told their friends about the violence, whereas 52% told their parents or another adult. Nearly a quarter (or 24%) sought help for sexual and dating violence from a health professional, teacher, or guidance counselor.

Youth experience adverse health outcomes linked to physical and sexual dating violence. Both victimization and perpetration of physical and sexual dating violence is linked with adverse health outcomes for youth. Youth currently experiencing physical *and* sexual violence in their dating relationships are nearly two times more likely to report high emotional discomfort and three-and-a-half

times more likely to report high physical discomfort than youth not currently experiencing this violence. Likewise, youth who report either experiencing or perpetrating sexual violence in their current dating relationship are two-and-a-half times more likely to rate their health as fair to poor than youth who are not.

Dating violence does not occur in a vacuum: Perpetrating other forms of youth violence is associated with perpetrating physical and sexual dating violence. For boys, carrying a weapon within the last 30 days and/or gang membership in the past year were both risk factors for perpetrating sexual violence against an intimate partner. Girls who reported being in a physical fight within the past year were more likely to perpetrate physical violence against a dating partner than girls who did not.

Youth who have experienced nonpartner sexual violence are at an increased risk of being either a perpetrator or a victim of dating violence. Of the youth who reported nonpartner sexual violence, 19% reported sexual violence in an intimate relationship in their lives. Boys with a history of nonpartner sexual violence are almost four times more likely to report physical dating violence victimization than males without this history. Likewise, females with a history of nonpartner sexual violence are almost three times more likely to experience physical dating violence than females without. Nearly one in five youth that have experienced sexual violence have experienced *both* partner and nonpartner sexual violence.

Young people care about this issue:

“Now I know how cruel people can be when they take you for granted and do sexual things to you without your okay to do it...”

—17-year-old female

“It made me feel so bad about myself I tried suicide.”

—16-year-old female

“I think that strong communication, trust, and lots of support between people can help reduce sexual or dating violence. Also I feel that information should be everywhere, in case people do need help.”

—18-year-old male

“I haven’t been in an unsafe relationship that was seriously unsafe, just one or two events with one partner that I felt unsafe. But I see in other people’s relationship and if my friends go through it, it hurts.”

—16-year-old female

School principals care about this issue:

“We knew it would be a valuable study that would provide us with a great deal of information about our students. Once we saw the results, we shared them with the entire school community because it was important to educate everyone about the problem.”

—participating school principal

“Conflict and violence in dating relationships is a large problem in our city and in my school, and it is imperative to better understand how we can help our young people maintain healthy relationships.”

—participating school principal

Everyone should!

This study recommends following a two-pronged strategy: preventing sexual and dating violence among NYC youth and providing appropriate response to those who have experienced this violence. Pursuit of these strategies simultaneously is essential to address the scope of sexual and dating violence occurring among the young.

Based on this data, the study recommends:



Schools and programs that work with youth should include a focus on primary prevention. Primary prevention focuses on examining and addressing the root causes of violence so that it can end *before* it occurs.

Teens should have access to youth-friendly, culturally appropriate, and language-appropriate referral information. Given that teens disclose incidents of sexual and dating violence to friends first, providing them with referral information is key to helping them support each other and reducing the stigma around sexual and dating violence. One such resource that the Alliance developed is the NYC Teen Health Map: a subway map on one side and a youth-friendly referral guide on the other, which folds into a discreet card to be tucked into the wallet. The referral guide includes information for youth who may have experienced sexual violence, hotlines to call, free counseling locations, and healthcare centers in each of the five boroughs (see text box: NYC Teen Health Map, page 72).



School personnel and others who work with youth should be trained how to properly handle disclosures and refer youth to services. Since many youth who have experienced sexual and dating violence tell someone about that violence, it is imperative that all those who work with youth are trained in how to properly handle disclosures and how to refer youth to services. Proper responses to disclosures of sexual and dating violence require that sensitivity and respect be given to the survivor. This training should be inclusive of several audiences: youth workers, including after-school program staff; school staff, including principals, teachers, guidance counselors, nurses, security guards, and janitors (among others); and healthcare professionals. This means that appropriate policies and procedures *must* be implemented in these settings.



Healthcare professionals should speak with adolescents about sexual and physical violence. This study expanded on the growing body of literature that shows the connections between sexual and physical violence and adverse health outcomes. These associations highlight the importance of talking about sexual and relationship violence during youth healthcare visits. Healthcare professionals, when assessing the health of teenagers, must consider the impact of current sexual and physical violence and past sexual abuse in contributing to the presentation and exacerbation of physical and emotional symptoms.

How has dating violence or sexual violence affected you?

“It affected me very much because sometimes I can’t even concentrate in school and am also making my parents worry about me.”

—18-year-old female

Chapter 1: Introduction

Defining Sexual Violence and Dating Violence

Throughout this report the terms “sexual violence” and “dating violence” are used to talk about the wide array of violence affecting the lives of youth. “Dating violence” occurs when one partner attempts to maintain power and control over the other through one or more forms of abuse, including sexual, physical, verbal, and emotional abuse (NCADV, 2008). Dating violence affects males and females from diverse racial, social, or economic backgrounds.

“Sexual violence” occurs both within and outside of dating relationships. Sexual violence refers to sexual activity during which consent is not obtained or freely given (CDC, 2007). Like dating violence, anyone can experience sexual violence, and the perpetrator in most cases is someone known to the victim (Bureau of Justice Statistics, 1997). Sexual violence can include physical contact between the perpetrator and victim, such as unwanted touching and forced sex, as well as nonphysical violence, including sexual harassment, threats, intimidation, stalking, and peeping. For this study,

Key Terms Used in this Report

Sexual violence: unwanted sexual fondling, touching, oral sex, or sexual intercourse (penetration of the vagina or anus with a penis, fingers, or an object).

Centers for Disease Control and Prevention (CDC): *Sexual violence* is divided into three categories: (1) Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; (2) an attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act *e.g.*, because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure; and/or (3) abusive sexual contact (Saltzman *et al.*, 2002)

World Health Organization (WHO): Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or [acts] otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home or work (Jewkes, Sen, and Garcia-Moreno, 2002).

Dating violence: includes sexual, physical, verbal, and emotional abuse in the context of an intimate relationship. In this report, the study focused on unwished-for sexual and physical force rather than emotional and verbal.

Nonpartner sexual violence: perpetrated by a person of any gender who could be a stranger to the victim. It can be also perpetrated by someone known to the victim with whom they do not have a romantic relationship, such as: a parent, family member, older acquaintance (family friend, teacher, minister, neighbor, etc.), and/or a peer who is not a partner.

Current partner: a partner from a relationship within the past 12 months. This term is used throughout the report to measure experiences with dating and sexual violence within the past year.

Ever partner: any partner, current or previous. This term is used to measure the lifetime experiences with physical and sexual violence by a partner.

Victimization: when a person (in this report a high school student) was/has been/is subjected to dating violence or nonpartner sexual violence.

Perpetration: when a person commits an act of dating violence or nonpartner sexual violence against another person.

“sexual violence” or “sexual abuse” is defined as any sexual fondling, touching, oral sex, or sexual intercourse (penetration of the vagina or anus with a penis, fingers, or an object). The phrase “sexual and dating violence” refers to youth experiences of both partner violence (physical and/or sexual) and nonpartner sexual violence. These terms are used together, since many youth reported experiencing both types of violence and the risk and protective factors overlap.

Overview of Sexual and Dating Violence among Youth

Nationally, between 7% and 10% of girls ages 12–17 have experienced some form of sexual assault, rape, or child sexual abuse (Deomampo, 2007). Sexual and dating violence disproportionately affect youth, with young women ages 16 to 24 experiencing the highest rate of intimate partner violence (USDODJ, 1997). The National Crime Victim Survey indicates that adolescent females ages 16 to 19 are four times more likely than the general population to experience sexual assault, rape, and attempted rape (Rennison, 2002). The National Center for Juvenile Justice estimates that in two-thirds of sexual assault cases reported to U.S. law enforcement agencies, the victim was younger than 18 at the time of the crime. These numbers are of concern given that *reported* violence is often just the tip of the iceberg. Thus, it is not surprising that sexual violence is often referred to as a “hidden crime” or “silent epidemic,” as rape and sexual assault are so infrequently reported to the police and other authorities (Harner, 2003).

Recent research has also focused on violence in young people’s dating relationships. One study found that one in five female high school students reported experiencing physical and/or sexual violence from a dating partner (Silverman *et al.*, 2001). Another study of nearly 2,000 eighth and ninth grade students revealed that 36% of adolescents in relationships reported being the victim of at least one episode of nonsexual dating violence, and 11% of these had been a victim of at least one episode of sexually violence in their dating relationships (Foshee *et al.*, 1996).

Among NYC Youth

In a study of urban female adolescents ages 14 to 23 who presented for health services at Mount Sinai Adolescent Health Center, approximately one in four reported having an unwanted sexual experience in the past year (Rickert *et al.*, 2004). A study of young NYC women between the ages of 15 and 24 visiting the Planned Parenthood clinic found a high prevalence of dating relationships characterized by physical violence (22%), coercion (60%), and forced sexual experiences (27%) (Davidson, 2004).

With the Youth Risk Behavior Survey (YRBS) data, the NYC Department of Health and Mental Hygiene (DOHMH) found that from 1999 to 2005, dating violence increased by more than 40%, meeting national prevalence levels in 2005 (Olson *et al.*, 2007). According to 2007 YRBS data, which asks one question about physical violence, one in nine New York City teens (11%) report experiencing being physically hurt by a partner. Girls are no more likely than boys to have been physically hurt by a partner, but girls are more likely to have been forced to have sex by someone (9% of girls vs. 7% of boys) (NYC DOHMH, 2008).

The New York City Domestic Violence Hotline receives an average of a thousand calls from teenagers every month (Mayor’s Office to Combat Domestic Violence (MOCDV, 2006)). Very few of these youth seek out formal services, as only approximately 10% of domestic violence victims seen in the city’s public hospitals are under the age of 20 (MOCDV, 2005).

The violence experienced by youth can be lethal: Nearly half of all female homicide victims in New York City are killed by an intimate partner. Of these intimate-partner homicides, teenagers make up approximately 8% of victims, or 4% of all female homicides in New York City (Wilt, Illman, and Brodyfield, 1996).

Focus of the Research

What are the prevalence, nature, and experiences of sexual and dating violence among New York City high school students? This question was the main focus of the research study conducted jointly

Table 1: Prevalence of Sexual Violence among Youth in NYC: Selected Studies 1997–2007*

Authors and Year	NYC Sample	Methodology/Design	Findings
Eastwood, E.A. and J.M. Birnbaum, 2007	224 adolescents with HIV seen at an adolescent medicine clinic in NYC	Longitudinal survey	43% of adolescents surveyed reported experiencing sexual abuse
Olshen, E., <i>et al.</i> , 2007	Youth Risk Behavior Survey 2005 data for NYC; population-based sample of 8,080 students at 87 public high schools	Survey	Lifetime history of sexual assault was reported by 10% of females and 5% of males; dating violence in the past year was reported by 11% of females and 9% of males
Diaz, A., <i>et al.</i> , 2004	146 female patients aged 12–22	Direct physician inquiry of adolescent females during routine history-taking and medical examination	Of the 141 female adolescents for whom no history of sexual victimization was known at the time of the routine medical history and physical examination, 32 (23%) disclosed a history of sexual abuse
Rickert, V.I., <i>et al.</i> , 2004	689 female adolescents between 14 and 23 who presented for health services at the Mt. Sinai Adolescent Health Center	Cross-sectional survey	Approximately 1 in 4 urban young women reported having an unwanted sexual experience in the past year
Dunlap, E., Golub, A., and B.D. Johnson, 2003	98 female subject from 72 severely distressed families in Central Harlem, South Bronx, Brownsville, and East New York	Longitudinal ethno-graphic study: semi-structured interviews, rapport of long-term relationship, and direct observation	Adult sexual contact with young girls was widespread and even the norm in many impoverished inner-city households; the majority (60 of 98) of the participants reported having been compelled to have sexual contact by the age of 13
Freudenberg, N., <i>et al.</i> , 1999	169 young people between 12 and 21 completed semi-structured interview; 27 young women participated in focus groups; 194 incarcerated males 16 to 18 years old completed interviews	Street survey, focus groups, interviews, and observations of several youth programs	20% reported that they had experienced unwanted sexual touching or rape; the young men interviewed in jail described considerable levels of violence; more than one-quarter (26%) reported they had been physically or sexually abused
Molnar, B.E., <i>et al.</i> , 1997	775 homeless and runaway youth (in Denver, NYC, and San Francisco)	Survey	Among females, 70% reported sexual abuse and 35% reported physical abuse; sexual and physical abuse before leaving home were independent predictors of suicide attempts for females and males

*From: Deomampo, D. (2006).

by the NYC Alliance Against Sexual Assault and the Columbia University Center for Youth Violence Prevention.

Additional research questions included: What is the degree and nature of mutual participation of youth in violence within their relationships? What implication does this have for developing prevention programs for dating violence? Also, how is dating violence associated with exposure to other forms of violence?

This research seeks to improve understanding of youth experiences of sexual and dating violence, with the equally important goals of improving services for youth experiencing violence and preventing sexual and dating violence before it occurs.

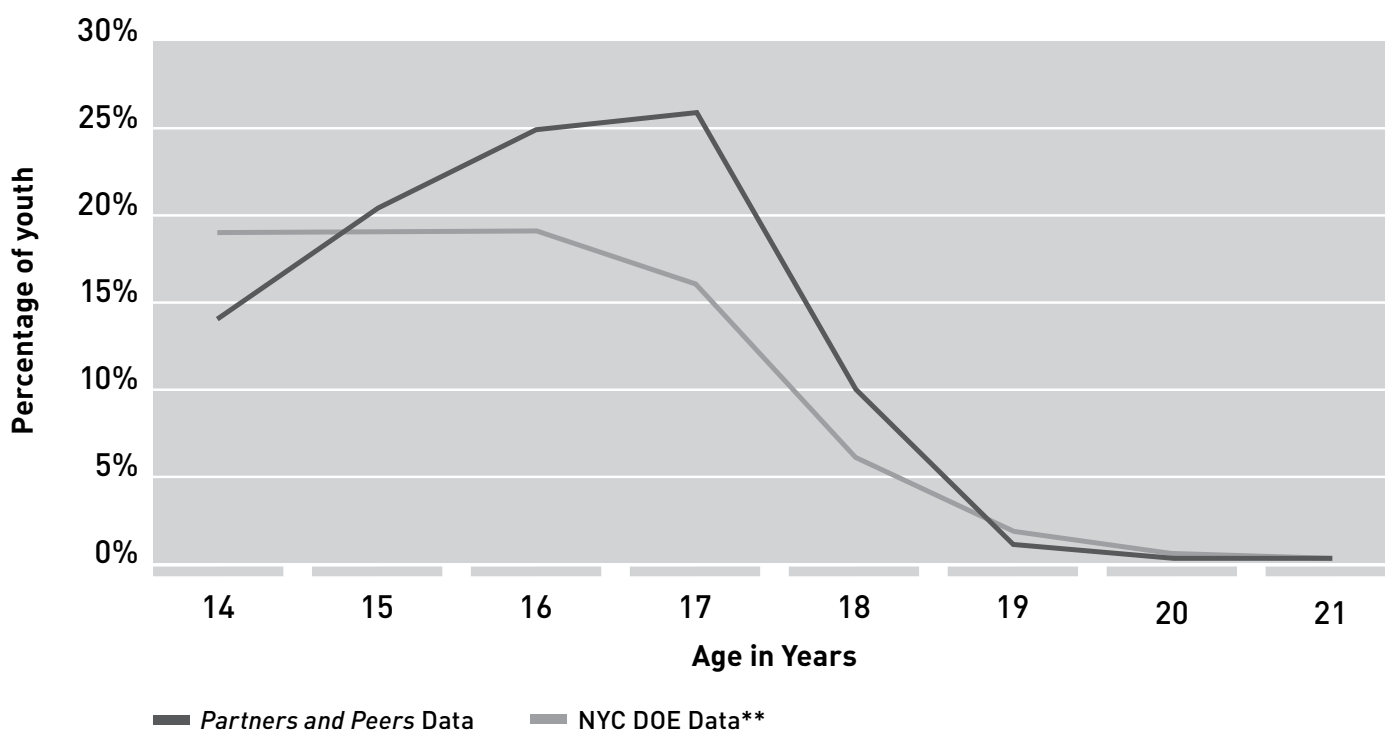
Though much of the violence this study reports is not severe, some of it is, including rape and potentially lethal actions. The study cannot come to any conclusions about the relationship of moderate

sexual and physical violence to the more severe end of the spectrum. Answering that question requires a larger, long-term study. It may be that the high proportion of young people experiencing coercion and violence in their dating relationships is not related to the more serious battering relationships that lead to disability and/or death. Nonetheless, it is clear from the research described in this report that even the mild end of this spectrum is harmful to the young people experiencing such violence.

Participants in the Study

The Alliance and CCYVP surveyed 1,454 students at four high schools in New York City during the 2006–2007 school year. Of these, 64 surveys were incomplete and were eliminated. (See, for detailed explanation of sampling procedure, Appendix A: Methodology, on page 75.) The total sample size for the analyses presented in this report is 1,312.

Figure 1: Age Distribution of Sample Compared with NYC Data*



*Both *Partners and Peers* sample and NYC DOE data is for the 2006–2007 school year.

**NYC DOE data obtained from the NYC Department of Education is for the 2006–2007 school year. Age is calculated as of October 31, 2006. This data includes youth in all NYC public schools.

The overall response rate for the study was 70% of students in the four schools.

Of the youth surveyed, 56% (737) were female and 44% (574) were male (with the data from one survey missing the answer to gender). Figure 1 represents the age distribution in the sample compared with the age distribution of all students in NYC public high schools. The majority of youth in this study were 15–16 years old. The distribution across grade levels was nearly equal, with 28% of youth in grade nine, 25% in grade ten, 24% in grade eleven, and 23% in grade twelve, with approximately one-quarter of participants in each grade. These schools were not chosen as representative of the whole population of NYC youth.

The majority of participants identified as Latino (73%), with the remainder identifying as black (19%), Asian (3%), and white (2%). Of those who reported Latino ethnicity, 53% identified as Dominican, 26% as Puerto Rican, and 3% as Mexican. More than three-quarter (77%) of those surveyed were born in the United States and 66% spoke English at home. Of those who spoke another language at home, 91% spoke Spanish, 6% spoke Chinese, and the remaining 4% of students spoke either Creole, French, Korean, or another language.

Three-quarters (78%) of students reported that they were not working. More than half (51%) reported living in a one-adult household, and 52 youths (4%) reported that they did not live with any adults.

Youth Relationships and Sexuality

Of the 1,312 students with sufficient data, the majority identified themselves as heterosexual (91%), with the remaining identifying as homosexual, bisexual, or “not sure.”

The majority of student surveyed (78%) reported they had started dating or had at least one romantic relationship at the time of the survey. Almost nine out of ten of them were in a current relationship. When thinking about a recent relationship, 51% reported dating that person exclusively, and 71% reported that the relationship was important or very important to them. The range of relationship length varies, with 17% of youth reporting they dated their current or most recent partner for less than one month, 21% report that the relationship lasted between one and three months, 16% reported between three and six months, and 17% reported between six months and one year. Nearly a third of the respondents (30%) reported they are with or have dated the same partner for more than a year.

Approximately two-thirds (63%) reported being sexually active in the past year. Thirty-eight percent reported they had not had sex with their partner, 48% reported they had sex only with their partner, and 6% reported having sex with people other than their partner.

Of the youth surveyed, 14% of girls reported they had ever been pregnant, and 12% of boys reported they had made someone pregnant. Less than one-third of these young women had been pregnant two or more times, and less than half of the young men who had made someone pregnant had done so on two or more occasions. In addition, 16% of these young women reported they have one or more children, and 21% of these young men reported having one or more children.

How has sexual violence affected you?

“It makes me suffer. All it does to me is that it makes me feel less okay as a person.”

—14-year-old female

Chapter 2: Nonpartner Sexual Violence

This study assessed the prevalence of nonpartner sexual violence among surveyed youth and measured who perpetrated this violence.

Nonpartner Sexual Violence: What Other Studies Show

In the United States, adolescents between the ages of 12 and 19 are sexually assaulted at rates higher than any other age group (Catalano, 2004). According to the National Crime Victimization Survey, teens age 16 to 19 are three-and-a-half times more likely than the general population to be victims of rape, attempted rape, or sexual assault (Bureau of Justice Statistics, 1996). The National Violence against Women Survey also found that rape is a crime committed primarily against youth. Of the women who reported being raped at some time in their lives, 22% were younger than 12, 32% were between the ages of 12 and 17, and 29% were between the ages of 18 and 24 when they were raped (Tjaden and Thoennes, 1998). More than half of female victims were younger than 18 at the time of the rape.

More than three-quarters (77%) of all completed rapes are committed by someone who is known to the victim (Bureau of Justice Statistics, 1997). According to the National Survey of Adolescents, 74% of youth who reported a sexual assault (4,023) were assaulted by someone they knew well—32% were friends and 21% were family members (Kilpatrick, Saunders, and Smith, 2003).

Sexual violence perpetrated by an adult of any gender who is related to the victim is called “intra-familial” sexual abuse. Prevalence of parental child sexual abuse is difficult to assess due to secrecy, but it is estimated that 20 million Americans have been victimized by parental incest as children (Turner, 1996). One of the nation’s leading researchers on child sexual abuse, Dr. David Finkelhor, reviewed 19 studies and found that most

sexual abuse is committed by men (90%) and by persons known to the child (70%–90%), with family members constituting one-third to one-half of the perpetration against girls and 10% to 20% of the perpetration against boys (Finkelhor, 1994).

Sexual violence is also perpetrated against youth by other youth. According to the Bureau of Justice Statistics, about one-quarter of sexual assault incidents involved offenders younger than 21 (Greenfield, 1996). In a national study of 1,600 juvenile sex offenders, 25% perceived sex as a way to feel power and control, 9% as a way to dissipate anger, and 8% as a way to punish (Ryan *et al.*, 1996).

Sexual abuse early in life has been implicated in vulnerability to repeat sexual victimization—both chronic abuse and future abuse by a different person. Studies have found that women who experienced sexual assault in childhood were two to three times more likely to be raped or sexually assaulted after the age of 16 (Gidycz *et al.*, 1993; Kilpatrick *et al.*, 1997; Tjaden and Thoennes, 2000; Siegal and Williams, 2003). Recently, Classen and colleagues (2005) reviewed 90 empirical studies focused on the prevalence of and risk factors for sexual violence revictimization, and confirmed the elevated risk of sexual assault among child sexual-abuse survivors. Desai *et al.*, (2002) found rates of sexual reassault were even higher for male survivors of childhood sexual abuse: They were almost six times more likely to be revictimized in adulthood.

Research shows a link between a history of sexual abuse and subsequent physical violence in a dating relationship. In a study of undergraduate women, those that were child sexual-abuse survivors were more than two times as likely to experience physical dating aggression and three times as likely to experience psychological aggression in a dating relationship as nonabused women (Banyard, Arnold, and Smith, 2000).

What This Study Measured

This study measured experiences of nonpartner sexual violence. Regarding nonpartner sexual violence, students read the following definition:

Many people experience sexual violence outside of dating relationships, both by people they know and by strangers. This section asks what types of sexual violence you may have experienced in your life. When we ask about “sexual abuse,” we mean any sexual fondling, touching, oral sex, or intercourse (penetration of the vagina or anus with a penis, fingers, or object).

Students were then asked, How often in your life has (including an option for never):

- Your parent sexually abused you or forced you to have sex?
- A family member other than a parent sexually abused you or forced you to have sex?
- An older acquaintance (such as a family friend, teacher, minister, neighbor, etc.) sexually abused you or forced you to have sex?
- Someone else your age whom you knew but was not your partner sexually abused you or forced you to have sex?
- A stranger sexually abused you or forced you to have sex?

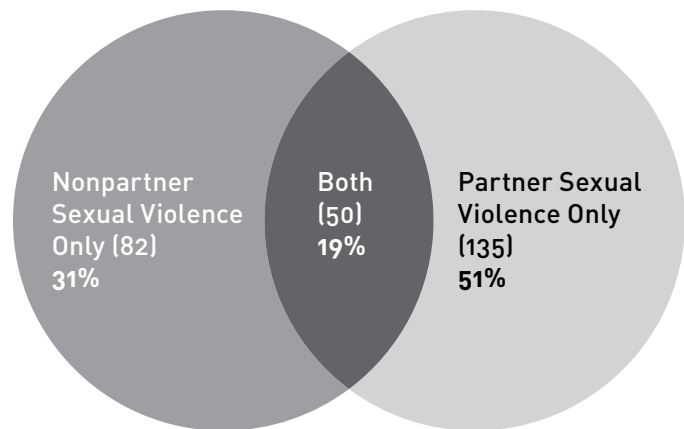
Partners and Peers: Research Findings

Sexual violence is prevalent among NYC youth. This study found that 16% (or more than one in six students) reported having experienced sexual violence at some point in their lives. Of these youth, 10% (or one in ten youth) reported a history of nonpartner sexual violence (sexual abuse or forced sex), and 14% reported a history of partner sexual violence (either current or past). Nearly one in five youth who had experienced sexual violence,

experienced *both* partner and nonpartner sexual violence (see Figure 2: Overlap between Nonpartner and Partner Sexual Violence Victimization).

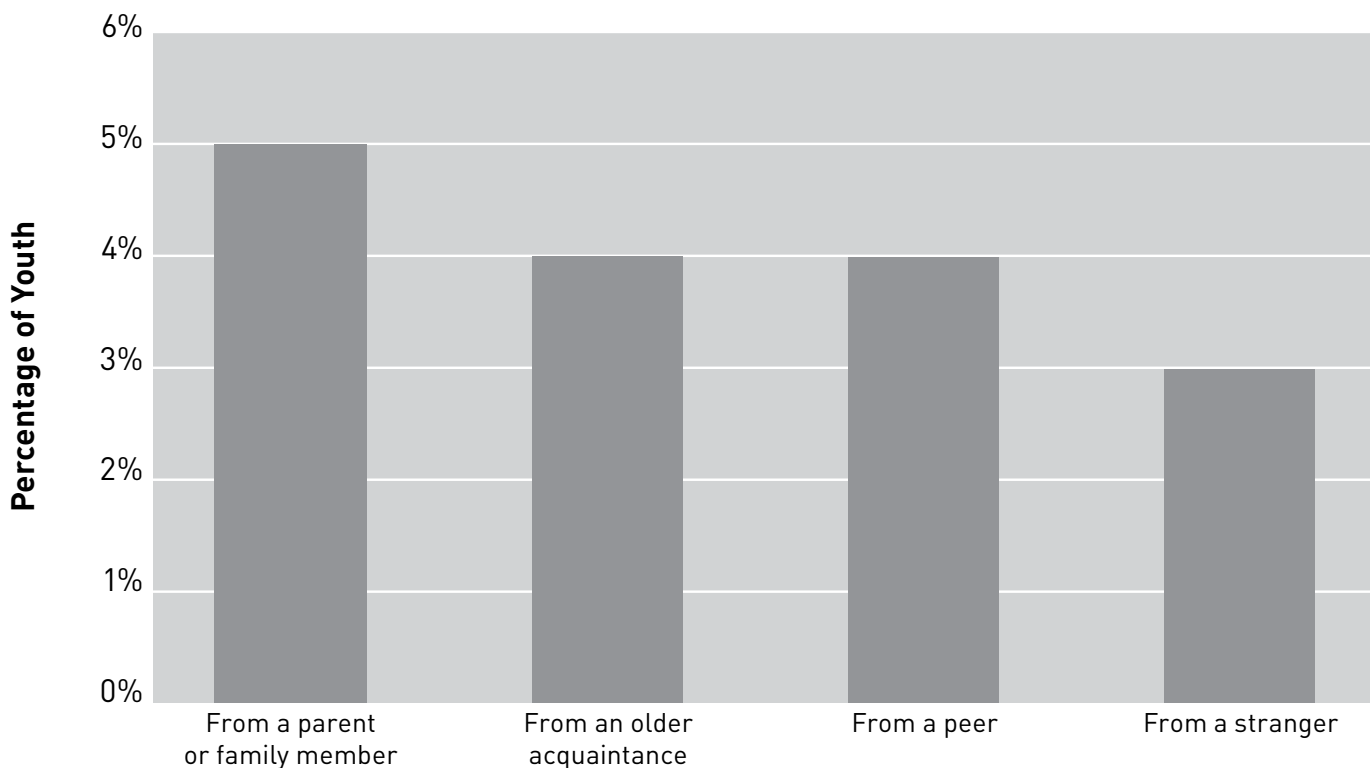
Youth who had experienced sexual violence were more likely to be female, including 79% of those who experienced nonpartner sexual violence, 70% of those who ever experienced sexual violence from a dating partner, and 53% of those experiencing sexual violence from a dating partner within the last year. The students were asked who perpetrated the sexual violence against them: a parent, other family member, older acquaintance, peer, or stranger (see Figure 3: Reported Experiences of Nonpartner Sexual Violence).

Figure 2: Overlap between Nonpartner and Partner Sexual Violence Victimization*



*Partner sexual violence questions from Dating Violence Inventory (DVI) and Family Abuse Scale, which measures violence in any dating relationship (current or past).

Figure 3: Reported Experiences of Nonpartner Sexual Violence*



*Denominator ranged from 1,284 to 1,288 students due to missing data on individual questions.

Familial Sexual Violence

A small percentage of youth (1%) reported experiencing sexual violence (sexual abuse or forced sex) perpetrated by a parent. Of these youth, the vast majority (83%) were female. An additional 4% reported ever experiencing sexual violence from a family member other than a parent, with girls representing 79%, and boys 21%. Familial sexual violence is often underreported among youth due to shame, secrecy, and sometimes threats from the perpetrators (see text box: Underreporting of Rape and Sexual Assault).

"I got molested twice by my uncle and no one knows it except a few friends and my mom."
—15-year-old female

Acquaintance Sexual Violence

Nearly 4% reported experiencing sexual violence from an older acquaintance such as a family friend, teacher, minister, or neighbor. The majority were girls (81% vs. 19% boys). Another 4% of youth reported experiencing sexual violence perpetrated by someone their own age they knew but that was not their partner.

"I was basically a victim of it. I was basically raped by my 15-year-old babysitter when I was seven..."

—15-year-old male

How Frequent Is Stranger Sexual Violence?

Of all the youth that reported sexual violence, 89% were victimized by an acquaintance, underscoring the finding that youth experienced sexual violence mostly from people they knew. Only 11% of all youth surveyed reported experiencing sexual violence from a stranger.

Underreporting of Rape and Sexual Assault

A small percentage of rape and sexual assault survivors actually report their experiences to the police and prosecute their perpetrator. A larger subset of survivors, however, tend to seek help at a rape crisis center or a medical facility, and an even larger subset will often confide in another individual; for youth, this may be a parent, a teacher, another adult, or, most often, a peer. Yet a significant number of survivors will tell no one about their assault, and while many may report their experience on an anonymous survey, not all will.

Indeed, measurement is a challenge for all surveys, but it is particularly difficult to measure and characterize incidences of rape and sexual assault across a population. Sable and colleagues (2006) explored a plethora of barriers to reporting rape and sexual assault among survivors. Most male survivors rated feelings of shame, guilt, and embarrassment as the leading barrier to reporting rape. Many men also stressed concerns about confidentiality and the fear of not being believed. Female survivors' top barriers to reporting were fears of retaliation by their perpetrator, financial dependence on their perpetrator, not wanting a family member or friend to be prosecuted, and a feeling that what they experienced was not serious enough to be considered "rape." Other common barriers to reporting include survivors' feelings of denial, self-blame, helplessness, and perhaps a previous, observed, or anticipated negative experience with reporting to a friend, counselor, and/or police officer.

These barriers are minimized in anonymous surveys, yet underreporting can still occur. One example is through the context of the survey and its impact on subjects' disclosures. In a crime survey, a survivor might be less willing to report a rape, particularly if they know their perpetrator, when the survey frames their situation as not just something that happens but as a serious criminal act. In the context of a rape and sexual assault survey, a survivor might not consider his or her own experience as fitting within the conception of a stereotypical "real rape" or "real victim" and

consequently will not report (DuMont, Miller, and Myhr, 2003).

Additionally, survivors may not feel or trust that anonymous surveys are truly confidential. If the survey is given in a classroom setting, for example, youth may fear classmates peering over and looking at their paper and, as a result, not disclose a rape or sexual assault. Youth have previous experience in writing or taking tests, having their tests or papers being read and reviewed by their teacher, and ultimately having the results of this work displayed on a final report card. Teachers often intervene when these results are considered negative or if the teacher is concerned about the student. Understandably, then, youth may not trust that a survey they fill out in school will be completely anonymous or without consequences. Thus, survivors' concerns about confidentiality and retaliation by their perpetrator never completely cease to be a barrier to reporting. Furthermore, the feelings of shame, guilt, embarrassment, fear of not being believed, denial, and/or self-blame do not simply disappear when a survivor is handed a survey, even if the survey is anonymous and conducted by outside researchers.

Finally, the nature of the relationship between survivor and the perpetrator can contribute to the level of disclosure. According to Alan Horowitz (1990), offenses that acquaintances commit do not evoke the same degree of moral outrage as offenses strangers commit, and people tend to define acquaintance violence as a private matter. Thus, subjects may not view sexual or dating violence as crimes or even problems that should be reported.

Anonymous surveys are currently the best tool available to assess rape and sexual assault within a particular population, but it is important to keep in mind that they are not perfect. Just as experiences of sexual violence are incredibly complex and traumatic for survivors, the decision to report and how to report such an experience is, likewise, far from simple.

Youth Voices:

How Has Sexual Violence Affected You?

"I hate hearing about rape. How could a person do such a horrible thing to another person? Rape is horrible."

—13-year-old female

"It has made me a very sad and depressed person. I have trouble trusting."

—17-year-old female

"It has changed me and has hurt me a lot emotionally."

—16-year-old male

"It makes me suffer. All it does to me is that it makes me feel less okay as a person."

—14-year-old female

"Well for two years I couldn't dress or act the same as I used to because of sexual violence."

—18-year-old female

"It makes me think that a lot of men can't be trusted."

—14-year-old female

"In many ways like sexually and abuse [has affected] my life because I'm afraid to connect with my partners."

—16-year-old female

"It gets me upset and feel like hurting the person."

—17-year-old female

"It has made me depressed and I shut out from everyone (secretive)."

—16-year-old female

"I think it made me stronger. Because even though it's in the past and I carry that throughout my whole life, I don't let that stop me."

—15-year-old female

"I feel that it is too fuckin' horrible and that if I am walking down the street and a guy is sexually abusing a girl, I would kill him."

—15-year-old male

"It has made me want to change my sex."

—14-year-old female

"It changed my behavior toward my boyfriend now because I experienced violence and sexual violence with my ex-boyfriend."

—17-year-old female

"I ask my partner questions and tell him over and over what I have been through."

—17-year-old female

"It has affected me very much because it is something I can't forget."

—18-year-old female

"It made me feel so bad about myself that I tried suicide."

—16-year-old female

"Now I know how cruel people can be when they take you for granted and do sexual things to you without your okay to it..."

—17-year-old female

"It didn't affect me. I just blank it out."

—17-year-old female

Revictimization and Continuous Abuse

Youth who experience sexual violence are at increased risk for ongoing violence or revictimization. Of those reporting nonpartner sexual violence, 40% (or one in three) reported experiencing the abuse more than once, and 19% experienced the abuse on three or more occasions. Youth who experienced sexual abuse from a family member other than a parent were the most likely to report ongoing sexual abuse.

Nonpartner Sexual Violence Is an Associated Factor for Dating Violence Victimization and Perpetration

Among youth who reported nonpartner sexual violence, 19% also reported sexual violence from an intimate partner at some point in their lives. Some youth with a history of nonpartner sexual violence also experience physical violence from a dating partner. Using logistic regression, controlling for age and race/ethnicity, the study found that males who had been a victim of nonpartner sexual violence were three-and-a-half times more likely to experience physical dating violence than males who had not. Similarly, females who had experienced nonpartner sexual violence were nearly three times more likely to experience physical dating violence than females without that experience.

A history of nonpartner sexual violence is an associated factor for perpetration of physical violence in a dating relationship. Girls with a history of nonpartner sexual violence were more than two times more likely to perpetrate physical violence against their dating partner. Likewise, boys who have experienced sexual violence were almost four times more likely to perpetrate physical violence against their partner than boys who did not have this history.

Experiencing nonpartner sexual violence was an associated factor for perpetrating sexual dating violence. This study found that males with a history of nonpartner sexual abuse are nearly four times more likely to perpetrate sexual dating violence in their relationships.

Youth-Produced Documentary: *It's Not about Sex*

"Before I never really thought about sexual violence because I didn't really care about it. But since sexual violence was chosen as a topic for our video, now I kind of think that men can stop sexual violence. And it's not about the way someone is dressing that makes you want to do that to them; it's what's inside of you. It's really who you are."

—David Brice, Brooklyn International High School

"My perspective on sexual violence has definitely changed. Doing this documentary has opened my eyes, and I no longer have the mentality of oh, it won't happen to me. I think everyone is at risk, and producing this documentary has made me more aware."

—Sara Siddique, City-As-School, Brooklyn

In 2007, thirteen NYC high school students developed a documentary called *It's Not about Sex* highlighting the prevalence of sexual violence. The youth produced the documentary through a course organized by the Education Video Center (EVC). The EVC is a nonprofit youth media organization dedicated to teaching documentary video as a means to develop the artistic, critical literacy, and career skills of young people, while nurturing idealism and commitment to social change. Founded in 1984, the EVC has evolved from a single video workshop for teenagers from Manhattan's Lower East Side to become an internationally acclaimed leader in youth media and education. One of the EVC's four core programs is Documentary Workshop, a 15-week credit-bearing course that teaches high school students from underserved communities across New York City to research, shoot, and edit compelling documentaries that examine issues of immediate relevance in their lives. In the spring of 2007, thirteen NYC high school students in Doc Workshop produced a documentary called *It's Not about Sex*.

It's Not about Sex takes a fresh look at the prevalence of sexual assault in contemporary society. The New York City Alliance Against Sexual Assault provided assistance to teen producers—who were shocked by the statistic that more than half of all rapes happen to people under the age of 18—to

search for the roots of the violence. They examine why many survivors of sexual crimes are afraid to report them. On their journey to understand this complex issue, they talk to people from all walks of life, from sex crimes prosecutors and antirape activists, to people in the sex industry. Producers challenge their own assumptions, while calling for society to take prevention seriously at an earlier age.

The EVC multiplies the impact of the videos by showcasing them in schools and community centers, as well as through film festivals and broadcast opportunities. Screenings include youth-led discussions with the audience, designed to engage participants in becoming involved in social change.

Before the film was finalized, the Alliance held a screening to provide feedback to the student producers, inviting several individuals and organizations in the field. The students received helpful advice to finalize their documentary, met key people, and were encouraged by fellow activists and organizers to further their campaign to take action against sexual violence. The EVC partnered with the Alliance to use *It's Not about Sex* to encourage youth to participate in the Alliance's Sexual Assault Yearly Speak Out (SAY SO!) and to promote the NYC Teen Health Map. They also worked together on a study guide that goes with the documentary: www.evc.org/store/videos/study-guides/its-not-about-sex-study-guide.

Since the completion of the film, youth producers of *It's Not about Sex* have continued to use their documentary to raise awareness about these issues and to inspire diverse audiences to take action. Youth producers were interviewed for a story written in the winter 2008 edition of *Sex, Etc.*, the teen destination for real, honest sexual health information, published by Answer, at Rutgers University. The Young Adult Library Services Association (YALSA) of the ALA chose the documentary for its Notable List of DVD and Videos for Young Adults in 2008.

To watch a clip of *It's Not about Sex* or for more information, go to the EVC's Website:

www.evc.org

How has dating violence affected you?

*“It makes me feel like if you are in love
you are trapped sometimes.”*

—16-year-old female

Chapter 3: Dating Violence

Dating violence is a hidden epidemic among youth in New York City. This chapter covers current literature on the prevalence of both physical and sexual dating violence. Findings from *Partners and Peers* are presented, including data on perpetration and victimization.

Dating Violence: What Other Studies Show

Dating violence can take many often-interconnected forms: sexual, physical and/or emotional. Teen dating violence prevalence estimates range from 9%–60%, including verbal, physical, and sexual violence (Cohall, Cohall, and Bannister, 1999). According to the U.S. Department of Justice, females ages 16 to 24 are more vulnerable to relationship violence than any other age group (Bureau of Justice Statistics, 2001).

According to the Centers for Disease Control Youth Risk Behavioral Surveillance System (YRBSS), each year, one in 11 adolescents reports being a victim of physical dating aggression (CDC, 2006). In a study of 635 high schools students, researchers found that 36% of teenage girls and 37% of boys reported receiving some form of physical aggression from a dating partner at least once (Molider and Tolman, 1998). Furthermore, by the time they are in high school, 54% of students report dating violence among their peers (Jafe *et al.*, 1992).

Often those studying dating violence do not include sexual violence. A study of the effects of teen dating violence on high school females found that one in five experienced either physical and/or sexual violence in their relationships (Silverman *et al.*, 2001). Teenage girls in heterosexual relationships are much more likely than teenage boys to suffer from sexual victimization (Jezl, Molider, and Wright, 1996).

What This Study Measured

This study asked questions about *lifetime* victimization of physical and sexual violence and *current* victimization and perpetration of dating violence. The report applied two validated scales to measure dating violence: the Conflict in Adolescent Dating Relationships Inventory (CADRI) and the Dating Violence Inventory (DVI) and Family Abuse Scale (see, for more information, Appendix A, on page 75).

The CADRI assesses the frequency of current or recent dating violence behaviors that happened during a conflict or argument with a dating partner at some point in the last year. The CADRI asks about victimization *and* perpetration behaviors.

For current partner sexual violence the study asked sets of three questions.

During a conflict or argument with my partner in the past year:

- I touched him or her sexually when he or she didn't want me to.
- She or he touched me sexually when I didn't want him or her to.
- I forced him or her to have sex when she or he didn't want to.
- She or he forced me to have sex when I didn't want to.
- I threatened him or her in attempt to have sex with him or her.
- She or he threatened me in an attempt to have sex with me.

For current partner physical violence the study asked sets of five questions.

Theories of Teen Dating Violence

Many researchers have sought to explain why violence occurs and persists in the context of intimate relationships. In light of gender, demographic, historical, and psychological factors, a variety of theories concerning dating and domestic violence exist. Indeed, many adolescents and young adults have observed, experienced, and/or perpetrated such violence, a fact that is particularly relevant, since it is during these formative, first relationships that youth establish habits and patterns that often persist into adulthood (Werkele and Wolfe, 1999).

Feminist theorists attribute dating and domestic violence to their context within a patriarchal society. Studies show that gender matters in cases of sexual violence; males holding traditional, male-dominated gender views are more likely to be perpetrators of violence, and females with traditional views are more likely to be victims. However, other studies have shown females are more likely than males to inflict nonsexual violence, though motives for this violence often vary by gender (Foshee, 1996).

Social learning theory applies to both males and females, focusing on the impact of observing domestic or dating violence at home during adolescence. According to the theory, adolescents that observe violence among parents interpret violence as an action that is accepted in the context of an intimate relationship, and interpret violence as a legitimate behavior in response to another's wrongdoing. Adolescents then interpret abuse and violence as "positively functional" while simultaneously failing to observe the effectiveness of other, nonviolent forms of problem-solving. Furthermore, adolescents see that those who employ violence are not punished. According to Albert Bandura (a pioneer of social learning theory), as adults, individuals will apply these abstract rules and principles learned during adolescence (Bandura, 1973; and Bandura, 1977).

Yet, social learning theory does not completely explain dating and domestic violence, since not all children who observe violence become perpetrators or victims, while some children who do not

observe violence at home nevertheless are perpetrators and/or victims of violence in their young adult and adult relationships. Indeed, given that family units do not exist in a vacuum, researchers have explored the role and impact of an individual's broader community and society. One study theorized that one's observations and experiences with their friends are more influential than any parental violence they observe or experience (Arriaga and Foshee, 2004). Another study hypothesized that individuals of lower socioeconomic status tend to have fewer resources with which to exert power in a relationship, such as money or prestige, and thus resort to violence (Holtzworth-Munrow and Stuart, 1994). Finally, many explain dating and domestic violence as part of a broader "culture of violence," in which violence observed within a small community or in the media causes many to believe violence is accepted, or at the very least, effective. Indeed, studies have shown that various forms of violence are correlated with each other and also related to, though not necessarily caused by, an individual's general patterns of low self-esteem, emotional disengagement, and antisocial behavior (Donovan and Jessor, 1985).

Researchers not only have hypothesized why domestic and dating violence emerge, but have sought to explain why such violence continues. Some theorize that many remain in abusive relationships in hopes of a return to the "honeymoon" or "make-up" phase of the relationship. Others may choose to accept abuse due to a feeling there is simply no possibility of escape. Stockholm syndrome occurs when victims feel a particular bond to their captor/abuser, due to their isolation from other normal relationships (Center for Problem-Oriented Policing, 2006). Finally, many choose to remain in abusive situations due to social and cultural factors; a victim may not merely face retaliation by his or her perpetrator, but may also often face social risks, such as isolation from the community (Bograd, 1999).

During a conflict or argument with my partner in the past year:

- I threw something at him or her.
- She or he threw something at me.
- I threatened to hurt him or her.
- She or he threatened to hurt me.
- I kicked, hit, or punched him or her.
- She or he kicked, hit, or punched me.
- I pushed, shoved, or shook him or her.
- She or he pushed, shoved, or shook me.
- I slapped him or her or pulled his or her hair.
- She or he slapped me or pulled my hair.

To examine whether youth had ever experienced dating violence from any partner, this study used the Dating Violence Inventory (DVI) and Family Abuse Scale, which asked two questions about sexual violence and five on physical violence.

How often in your life has any (current or previous) partner ever:

- Tried to force you into sexual activity?
- Raped you?
- Pushed or shoved you?
- Slapped or hit you?
- Punched you?
- Choked you?
- Hurt you with an object or weapon?

Partners and Peers: Research Findings

Links between Forms of Dating Violence Victimization

There is tremendous overlap between the various forms of dating violence. In this study, 71% of youth who experienced threatening behaviors from a dating partner also experienced physical aggression from that dating partner. Likewise, 63% of youth who reported experiencing sexual violence from their dating partner also experienced physical dating violence from that same partner.

Physical Dating Violence Victimization from Any Partner

This study asked youth how often any current or previous partner had ever hurt them physically. Among students with a dating history, more than half (56%) reported physical dating violence during a conflict or argument at some point in their lives. Among youth with a dating history, more than one-quarter (27%) reported ever being pushed or shoved by a dating partner and 17% reported being slapped or hit. Fifteen percent of youth reported that a boyfriend or girlfriend threw objects at them and 11% said that a dating partner punched them. Youth also reported experiencing very serious and potentially lethally violent behaviors from a dating partner, with 8% reporting a history of partner-choking, and 3% reporting a current or previous partner had hurt them with an object or weapon.

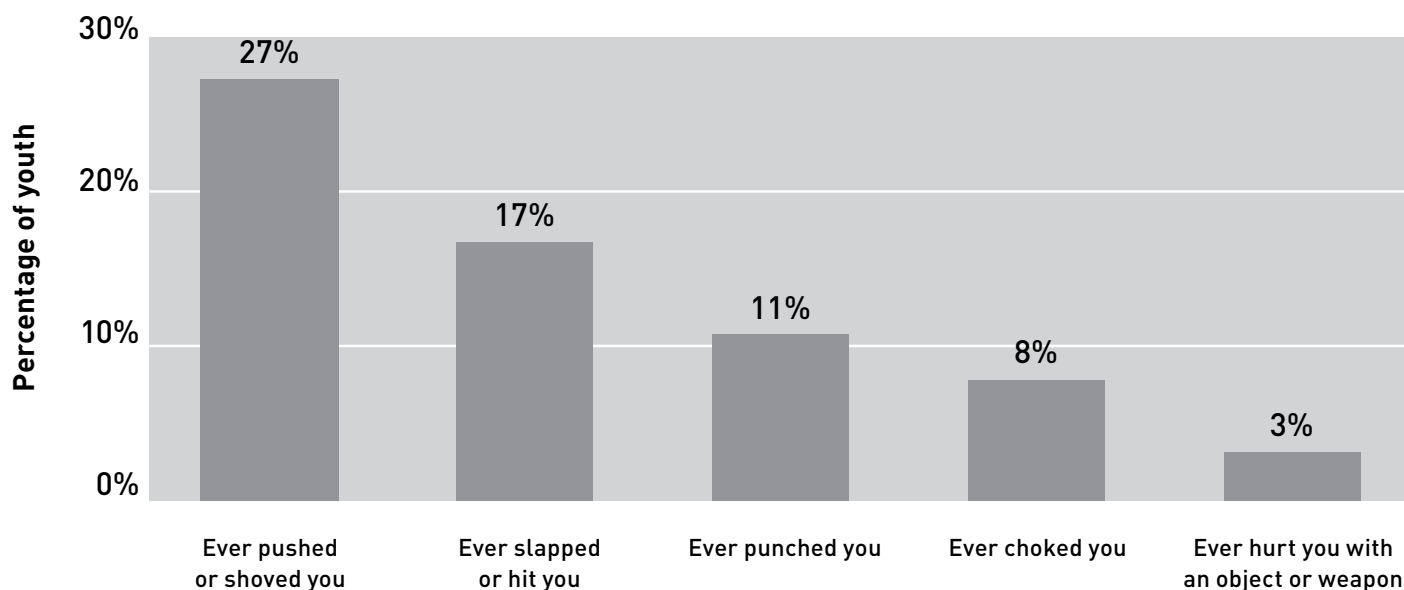
Physical Dating Violence Victimization from Current Partner

Many youth surveyed reported physical violence from a dating partner within the past year. The study asked youth if, during a conflict or argument with their partner during the past year, she or he threw something at them, kicked, hit, punched, pushed, shoved, shook, slapped them, or pulled their hair. Almost 30% of youth reported experiencing one of these behaviors and 32% reported that they had perpetrated at least one of these physically violent behaviors (see Figure 5: Youth Self-Reported Behavior and Experiences of Dating Violence).

“My mother went through it and I swore I won’t let myself become just another statistic.”

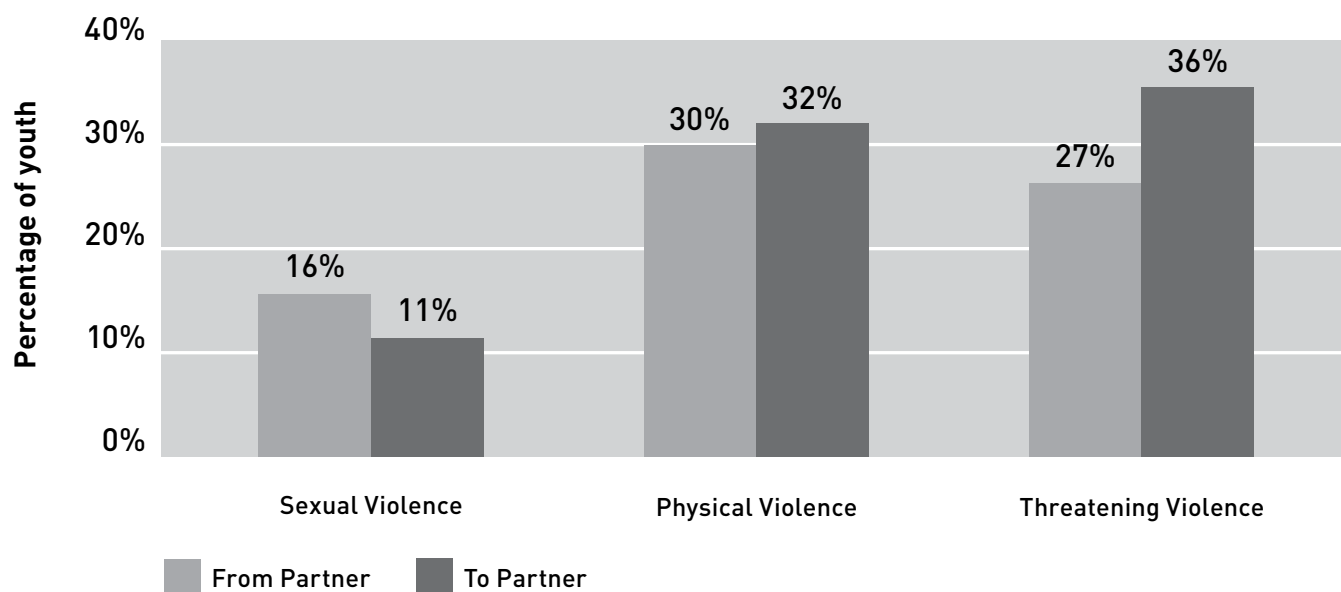
—17-year-old female

Figure 4: Percentage of Youth that Report Ever Experiencing Physical Dating Violence*



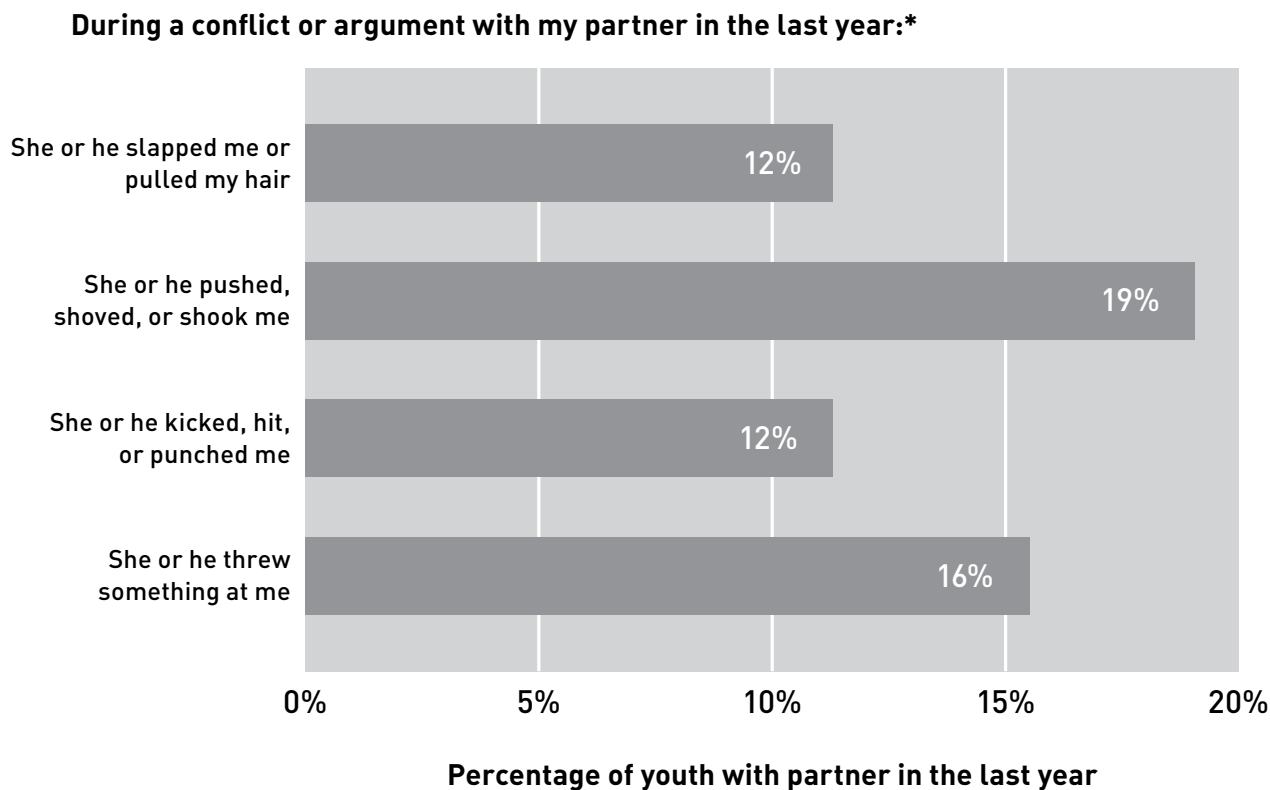
*Denominator based on (1,017) youth who had started dating or had any romantic and/or sexual relationship. The questions are from the Dating Violence Inventory (DVI) and Family Abuse Scale.

Figure 5: Youth Self-Reporting Behavior and Experiences of Dating Violence*



*Denominators based on (883) youth who reported having a partner within the last year. The scales are from the Conflict in Adolescent Dating Relationship Inventory (CADRI). The sexual violence scale is based on three questions and excludes forced kissing.

Figure 6: Percentage of Youth Who Report Experiencing Physically Violent Behaviors in Their Current Dating Relationship



*Denominators based on (883) youth who reported having a partner within the last year. The scales are from the Conflict in Adolescent Dating Relationship Inventory (CADRI). The sexual violence scale is based on three questions and excludes forced kissing.

During the past year, 19% of youth reported that their partner pushed, shoved, or shook them during a conflict or argument, 16% of youth reported their partner threw something at them, and 12% reported their partner slapped them or pulled their hair during a fight. More than one in ten students (12%) reported that their boyfriend or girlfriend kicked, hit, or punched them at least once during the past year during a conflict or argument. Seventeen percent of youth report being afraid of their partner when they argue or when they do something their partner doesn't like. Of these youth, 16% report being "quite a bit" or "very afraid" of their partner.

Physical Dating Violence Perpetration against Current Partner

Physical dating violence is not one-sided; many youth also report *perpetrating* physical violence against their partners. Approximately 32% of students reported perpetrating one or more episodes of physical violence against their partners in the past year. During a conflict or argument in the last year, 17% of youth reported that they kicked, hit, or punched their partner. Another 21% reported they pushed, shoved, or shook their partner at least once during a fight within the last year.

Threatening Behaviors from Any Partner

Similar to the mechanisms of control behind physical and sexual violence, many youth report experiencing nonphysical threatening behaviors from a dating partner. In this study, 12% of youth reporting that a partner ever threatened to hurt them. Another 4% of students reported that a partner (current or past) threatened to hurt them with a weapon.

Threatening Behaviors from Current Partner

The threatening behaviors are also occurring in current or recent relationships with slightly more than 17% of youth reporting their current or recent dating partner threatened to throw something at them during a conflict or argument, and four in

ten of these youth (42%) reported this happened to them three or more times during the past year. Nearly one in ten youth reported that their partner destroyed or threatened to destroy something they value during a fight. In addition, 10% of youth reported that their partner threatened to physically hurt them.

Sexual Dating Violence Victimization from Any Partner

Among students with a dating history, almost 10% reported experiencing sexual victimization by a romantic partner. Seventy-nine students surveyed (9%), reported that any dating partner (current or past) tried to force them into sexual activity. A smaller percentage, 3%, reported a history of forced sex by a partner.

Table 2: Youth Self-Reported Frequency of Physical Dating Violence Victimization and Perpetration within the Past Year

Physical Violence*	Never	Seldom (1–2 times)	Some (3–5 times)	Often (6+ times)
She or he threw something at me	84%	10%	4%	2%
She or he kicked, hit, or punched me	88%	6%	3%	2%
She or he pushed, shoved, or shook me	81%	12%	4%	2%
She or he slapped me or pulled my hair	88%	7%	3%	2%
<i>I threw something at him or her</i>	82%	10%	5%	3%
<i>I kicked, hit, or punched him or her</i>	83%	9%	5%	3%
<i>I pushed, shoved, or shook him or her</i>	79%	10%	8%	3%
<i>I slapped him or her or pulled his or her hair</i>	83%	10%	5%	2%

*Denominators based on youth who reported having a partner within the last year, and ranged from 840 to 883 for the questions about their partner's behavior and from 842 to 883 for their own behavior; ranges due to missing data on individual questions. The questions are from the Conflict in Adolescent Dating Relationship Inventory (CADRI).

Youth Voices:

How Has Dating Violence Affected You?

"Dating violence affected me emotionally when I was in a past relationship."

—16-year-old female

"It has somewhat because of the fact that I know my father used to abuse my mother."

—18-year-old male

"I'm paranoid that my partner or anyone just might try to hurt me."

—17-year-old female

"I haven't been in an unsafe relationship that was seriously unsafe, just one or two events with one partner that I felt unsafe. But I see in other people's relationship and if my friends go through it, it hurts."

—16-year-old female

"When I see someone getting abused I think it is wrong."

—13-year-old male

"I was in a violent relationship a long time ago and I think it made me less trusting in people."

—18-year-old female

"It educates me on how respectful you have to be with your partner."

—14-year-old male

"It has affected me very negatively. It has made me very sad and afraid. I have found it much harder to trust people."

—17-year-old female

"It has made me treat women better."

—16-year-old male

"You can say that it has made me a little scared of my partner and when we have fights I try to keep distance."

—17-year-old female

"I don't like to be around my partner because I believe that we may engage in physical violence."

—16-year-old male

"A lot because I don't believe in guys now and it is hard for me to get in a relationship with someone."

—17-year-old female

"Dating violence affected me because now I say to myself I shouldn't be in a serious relationship."

—18-year-old male

"Yes because it happened to my mother. The violence happened in front of me. Now I know what it is like."

—17-year-old female

"It affected the way she thought about me."

—15-year-old male

"In a way it makes me not wanna take a relationship seriously."

—17-year-old female

"It has affected me because I know some people my age that are in a violent relationship and it bothers me a lot."

—17-year-old male

Sexual Dating Violence Victimization from Current Partner

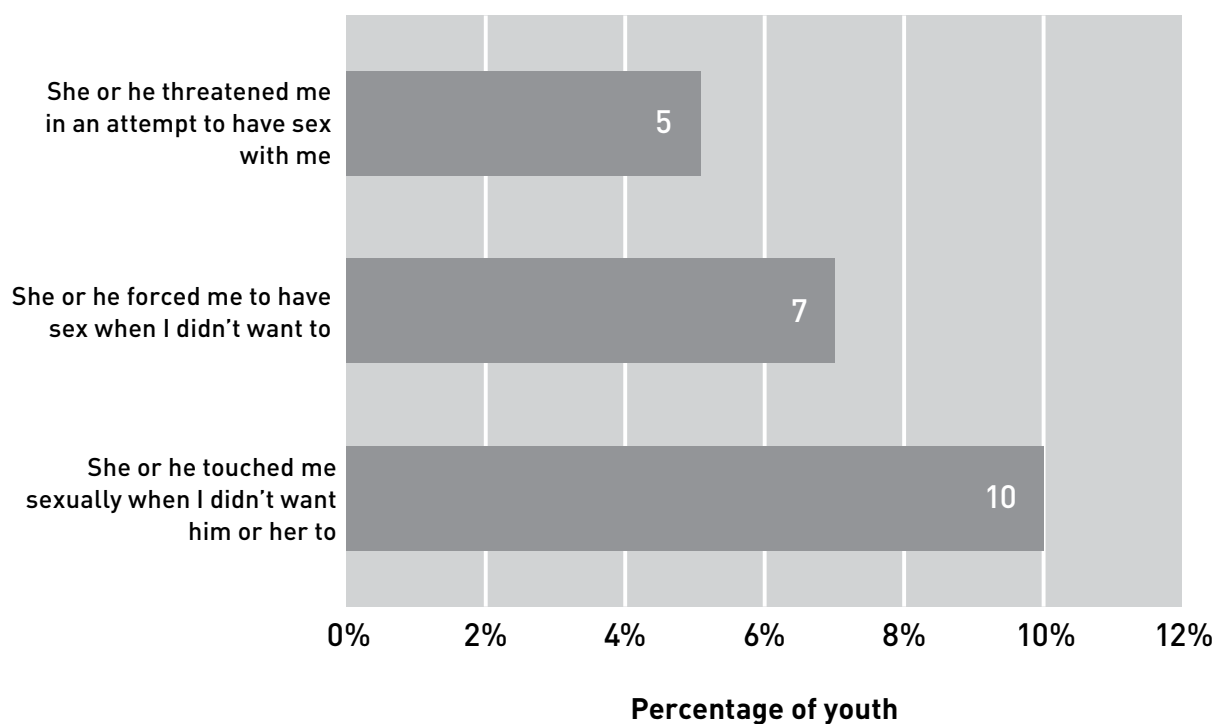
One in 20 youth (5%) reported their partner threatened them in an attempt to have sex, and an additional 7% said their dating partner forced them to have sex when they didn't want to at some point in the last year. Furthermore, nearly one in ten youth reported that their dating partner had touched them sexually within the past year when they didn't want him or her to.

Sexual Dating Violence Perpetration against Current Partner

This study asked students about their own perpetration of sexual violence in dating relationships. Seven percent of youth said they touched their partner sexually when their partner did not want them to. Another 4% reported forcing their partner to have sex against their will.

Figure 7: Percentage of Youth Who Report Experiencing Sexually Violent Behaviors in Their Current Dating Relationship

During a conflict or argument with my partner in the last year:*



*Denominators based on youth who reported having a partner within the last year, and ranged from 825 to 838; ranges due to missing data on individual questions. The questions are from the Conflict in Adolescent Dating Relationship Inventory (CADRI).

Fear as an Associated Factor for Current Dating Violence Perpetration and Victimization

This study asked students about the presence of fear in their dating relationships. Of the students surveyed, 20% of young women and 19% of young men are afraid of their partner, while 19% of young women and 24% of young men think their partner is afraid of them. In terms of bidirectional fear, 20% of young women who are afraid of their partner think their partner is afraid of them, whereas 13% of young men who are afraid of their partner think their partner is afraid of them.

As expected, the study found that when fear is present in dating relationships (whether it is bidi-

rectional or felt only by the victim), there is a higher rate of violence. Though fear is an associated factor for violence perpetration and victimization, this study cannot determine which comes first—fear or violence, because it is asking both questions at the same time, a cross-sectional approach.

How has dating violence affected you?

“I suppose I’m more paranoid around some people, especially when I anger them, and I cringe a lot more and try to protect myself whenever he yells, expecting worse.”

—17-year-old female

Table 3: Youth Self-Reported Frequency of Sexual Dating Violence Victimization and Perpetration within the Past Year

Sexual Violence*	Never	Seldom (1–2 times)	Some (3–5 times)	Often (6+ times)
She or he touched me sexually when I didn’t want him or her to	90%	6%	3%	1%
She or he forced me to have sex when I didn’t want to	93%	4%	2%	1%
She or he threatened me in an attempt to have sex with me	95%	3%	2%	1%
<i>I touched him or her sexually when she or he didn’t want me to</i>	93%	4%	2%	1%
<i>I forced him or her to have sex when she or he didn’t want to</i>	96%	2%	1%	1%
<i>I threatened him or her in an attempt to have sex with him or her</i>	96%	2%	1%	1%

*Denominators based on youth who reported having a partner within the last year, and ranged from 840 to 883 for the questions about their partner’s behavior and from 842 to 883 for their own behavior; ranges due to missing data on individual questions. The questions are from the Conflict in Adolescent Dating Relationship Inventory (CADRI).

Table 4: Controlling Behaviors Experienced by Youth

Controlling Behaviors*	
By a partner within the last 12 months...	
She or he kissed me when I didn't want him or her to	32%
She or he kept track of who I was with and where I was	59%
She or he tries to keep me from seeing my friends	20%
She or he tries to restrict contact with my family	6%
She or he insists on knowing where I am at all times	48%
She or he ignores me and treats me indifferently	19%
She or he gets angry if I speak to another man or woman	46%
She or he checks my cell phone to see who I have called	43%
She or he checks my email	21%
By any partner (current or past)...	
Ever made decisions for you	29%
Ever acted extremely jealous	52%
Ever insulted your family	15%
Ever insulted your friends	33%
Ever humiliated you in private	19%
Ever humiliated you in public	16%

* First half of table utilizes denominators based on youth who reported having a partner within the last year, and ranged from 838 to 881; ranges due to missing data on individual questions. These questions are from the Conflict in Adolescent Dating Relationship Inventory (CADRI). The second half of the table utilizes denominators based on youth who reported ever having a partner and ranged from 1,005 to 1,012, with ranges due to missing data on individual questions. These questions are from the Dating Violence Inventory (DVI) and Family Abuse Scale.

Marie's Story*

When I was thirteen, I began dating a childhood friend, a boy I had known since kindergarten. He was my first boyfriend, but more important, he was my best friend. My relationship with him gave me a feeling of security that I could not find anywhere else. Like a lot of teens, I was insecure. I had very little self-confidence, and I wanted nothing more than to feel accepted by my peers. It was with him and only him that I felt as if I could open up and be myself.

A few months after we began dating, I found out that my boyfriend had been dealing with a lot of problems at home. We had grown very close, and I found out that he had been physically abused as a young child by his father. His mother had taken him and left his father while he was still a little boy.

He had taken to drinking at that early age, and what other kids saw as cool had started to frighten me. I noticed changes in his personality when he would drink. He would get angry. There were times when he would threaten to kill himself, telling me that I was the only person that was keeping him from doing so. He attempted suicide twice while we were dating. I grew to feel hugely responsible for his wellbeing. I was in constant fear that I could not protect him.

Eventually, he grew violent with me. He had taken me to a party once. I found myself feeling particularly shy, unable to speak to anyone. I wanted desperately to leave. When I told him this, he grabbed my arm, pulling me into the bathroom. I felt my back thrust to the wall, and it seemed instantaneous that his fists were driven into my stomach, my sides, and my shoulders. I fought back tears that night, but I was unable to walk away.

This wasn't the first or last time that he had been violent toward me. I never told anyone about it as it was going on. I began to grow more and more withdrawn from my friends and family. They noticed that I wasn't myself, and they expressed concern, but I could never bring myself to let them know what was going on.

I am asked sometimes why I never told anyone—why I didn't just get help. In my head, I knew that he was wrong for hitting me. I knew that if I had told someone that it would probably stop one way or the other. But as I went through this experience, I found it easier to make excuses. I told myself that I knew he was sorry. In my head, I did not want to get him into

trouble. I did not want to go to the police or have him get "caught by the police." I would remind myself that he was dealing with a lot of hurt. I wanted to maintain his trust and to support him. I wanted him to believe I loved him. I was constantly scared that he would commit suicide.

I spent a lot of time in my life in a lot of pain. I had been diagnosed with anxiety. I spent many nights unable to sleep. I wanted to hide my experiences. I had always felt that women who stayed in abusive relationships were weak. I did not want to be considered that way. As a high school student, I became one of those "overachievers." I took only AP/Honors-level courses in school. I joined five or six activities after school. I wanted to keep myself busy, so that I would never have to confront what was happening to me.

The physical violence ended when his family moved across the country. I still spoke to him on the phone, and still bore the weight of feeling responsibility for his wellbeing. He committed suicide about five months after that move.

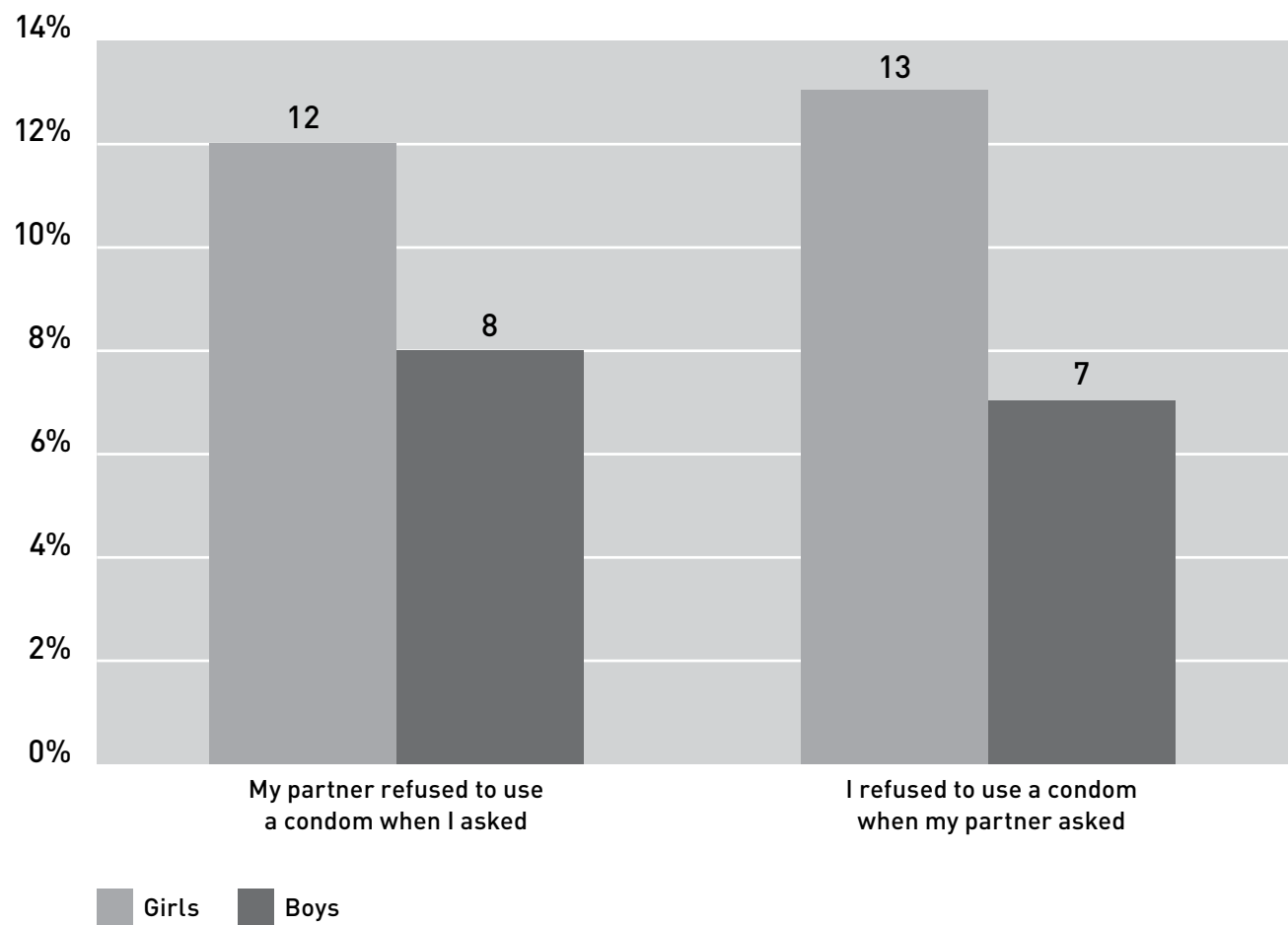
The first person I told was my college advisor. She was the first person to ever tell me that I was not to blame for this experience. She was the first person who ever pushed me to confront the experience, to understand it. It was the first step in my process of healing.

Eventually, I confided in my family, as well. They surprised me with their amount of support. They were shocked, but, at the same time, expressed how proud they were of my accomplishments in life and how that would never have changed. It showed me how much it means to have the community of support around me that my family has always given me. I had never told them, afraid I would have disappointed them in making the wrong choices.

I usually have one message for young people who may go through something similar: You are not alone. I have come to understand over the past few years how prevalent of a problem teen dating violence truly is. When I look back at my own situation, I always believed that I was alone. I believed that my situation was different. I wanted to feel as if I was doing the right thing by letting myself stay in the abusive relationship. What I know now is that if I had known I wasn't alone, I may have been able to help him and to help myself.

*Name changed to protect confidentiality.

Figure 8: Percentage of Youth Who Report Sexually Coercive Behavior with Condom Use*



*Denominators based on youth who reported having a partner within the last year.
Total was 516 youth, due to missing data on these individual questions.

Controlling Behaviors from Any Partner

In addition to violence and threatening behaviors, many youth reported being controlled by their dating partner. Controlling behaviors include monitoring a partner's behavior, insulting a partner's friends or family, and trying to restrict a partner's movement or interaction with support networks. Among the youth surveyed, 19% reported that a partner humiliated them in private, and 16% reported humiliation in public.

Many youth also reported experiencing controlling behaviors that limited or changed their interactions with family and friends. In fact, almost 15% of the students reported a partner insulted their family, and one-third (33%) reported that their partner insulted their friends.

Controlling Behaviors from Current Partner

Nearly 6% of students reported that a partner tried to restrict their contact with family at some point in the past year, and one in five students reported that a current or recent partner has tried to keep them from seeing friends.

Monitoring is a specific form of controlling behavior. In this study, nearly half of all youth (48%) said their current or recent partner insists on knowing where they are at all times. Another 43% of students say their partner checks their cell phone to see who they called, with more than half of these students (56%) saying this happens "sometimes" or "often."

Twenty-one percent of students report their partner checks their email, and 46% of youth report their current partner gets angry if they speak with another person of the opposite sex.

Many youth also experience sexual coercion and control related to the use of condoms during sex. Nearly one in five youth reported their partner refused to have sex using a condom, even when requested, with 12% of girls and 8% of boys reporting partner refusal. Likewise, a similar percentage of youth (20%) report they have refused to have sex using a condom—even when their partner asked them—with more girls (13%) than boys (7%) reporting refusal.

How has dating violence affected you?

“It has affected me because if my man hits me it makes me feel low and like a piece of garbage. Then I get reactive, get mad tough, and start fighting with anyone.”

—15-year-old female

Chapter 4: Intersections of Violence

Youth experience a range of violent behaviors during their lives and therefore it is important to examine the intersections of dating and community violence. This chapter examines the links between dating violence and other violent behaviors and experiences commonly reported by youth.

Dating Violence and Community Violence: Literature Review

Youth experience and are exposed to a wide range of violence, especially in urban settings. According to the 2007 NYC Youth Risk Behavior Survey (YRBS), 34% of students reported involvement in at least one physical fight in the past 12 months and 12% of students carried a weapon such as a gun, knife, or club on one or more of the past 30 days (NYC DOHMH, 2008). In addition, 7% of students did not go to school on one or more of the past 30 days because they felt unsafe at, or on their way to or from, school (NYC DOHMH, 2008). Both males and females in lower grades reported carrying a weapon more than youth in the higher grades (13% of ninth grade students vs. 9% of twelfth grade students). Furthermore, younger students also report more involvement in physical fights (34% of ninth grade females vs. 20% of twelfth grade females and 43% of ninth grade males vs. 31% of twelfth grade males) (NYC DOHMH, 2008).

Specific types of violence are unlikely to occur in complete isolation; for example, researchers found that adolescents who reported being abusive or violent in the past year, reported greater episodes of perpetration and victimization of dating violence and peer violence (Bossarte, Simon, and Swahn, 2008). Finkelhor and colleagues have explored the intersections of various types of victimizations on children and youth. Finkelhor argues that the research and practice fields have adopted a “fragmented” approach that explores specific victimizations in isolation and ignores the interrelationships

of these experiences. He argues for an examination of “polyvictimization,” or multiple victimizations across a range of crimes, including dating violence, child sexual abuse, familial violence, peer violence, as well as witnessing and other forms of indirect violence (Finkelhor *et al.*, 2005; Finkelhor, Ormrod, and Turner, 2007a).

In a national study, these researchers found a significant overlap between victimizations; that is, children and youth with a history of *any* sexual victimization were very likely (97%) to have additional victimizations. This includes, especially, an assault (82%), witnessing the victimization of another person, or being exposed to victimization directly (84%) (Finkelhor *et al.*, 2005). This category includes youth who have witnessed domestic violence, the physical abuse of a sibling, an assault (with or without a weapon), murder, a riot or other civil disturbance where shooting and/or bombing occurred, or had been in a war zone. This examination of polyvictimization allows for a better understanding of trauma symptoms and the need for broader prevention programming (Finkelhor, Ormrod, and Turner, 2007b).

Studies are also beginning to show the links between dating violence and other types of peer violence in terms of perpetration *and* victimization. In a study of Latino youth in Washington, DC, researchers found that youth who reported carrying a gun or involvement in physical fights were at increased odds of reporting dating violence (Howard *et al.*, 2005). The reverse also appears true; that is, researchers have found that youth who reported dating violence perpetration were almost five times more likely to report perpetration of other peer violence (Swahn *et al.*, 2008). Likewise, youth who reported dating violence perpetration were also at increased risk of being victimized through other peer violence (odds ratio: 3.24; confidence interval: 2.68, 3.91) (Swahn *et al.*, 2008).

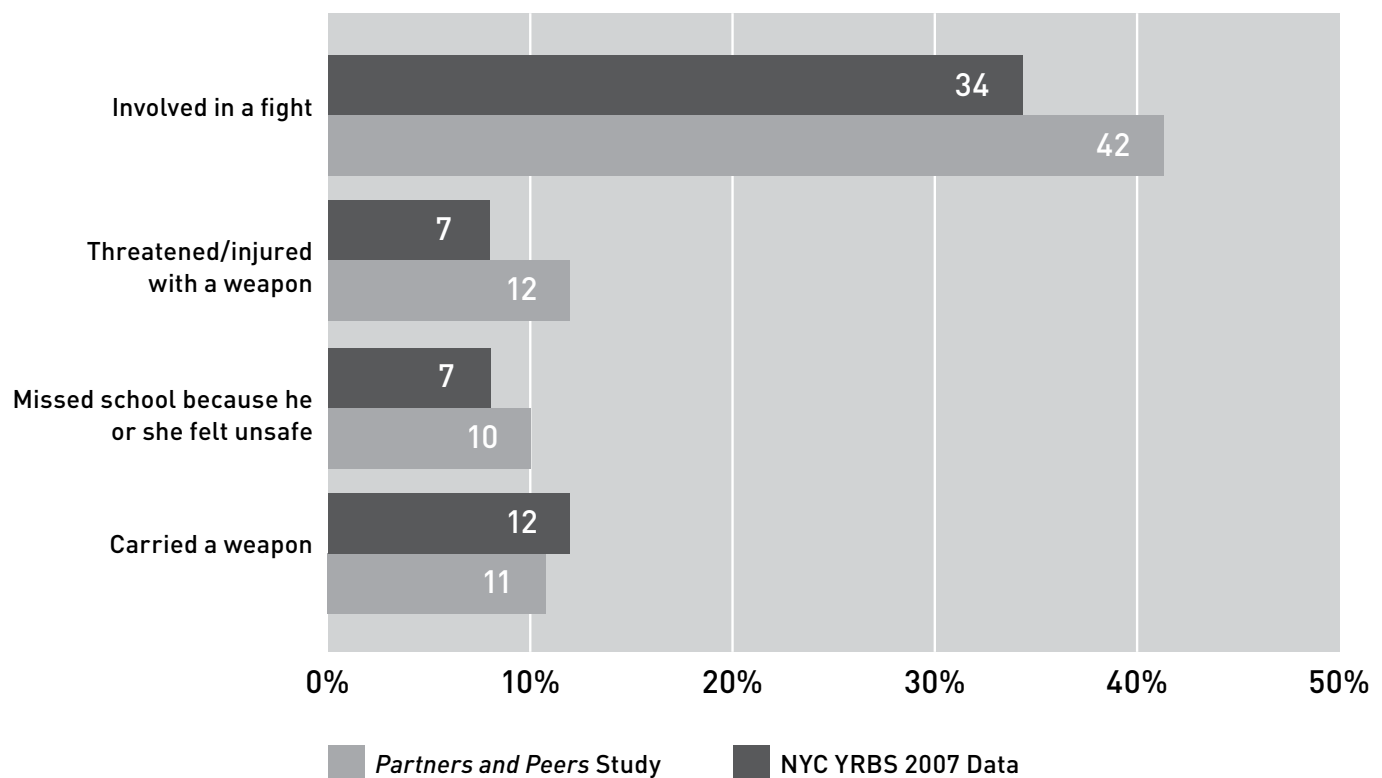
The more severe the violence, the stronger these relationships become, so that youth who reported perpetrating severe dating violence against a partner were almost eight times as likely to perpetrate severe violence against their peers than other youth (Swahn *et al.*, 2008). Likewise for victimization, researchers have shown that having been in a physical fight with a peer and having been hit by an adult with intention to harm were both risk factors for serious physical dating violence victimization (Foshee *et al.*, 2004).

What the Study Asked

The study asked five questions about general violence drawn from the Youth Risk Behavior Survey (YRBS):

1. During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?
2. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club?
3. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club?
4. During the past 12 months, how many times were you in a physical fight?
5. At any time during the past 12 months, have you been a member of a gang?

Figure 9: Comparison of NYC YRBS 2007 Data and Study Sample on Violence Indicators*



*Denominators based on entire sample of youth and ranged from 1,285 to 1,286. Ranges are used due to missing data on these individual questions.

Partners and Peers: Research Findings

Overview of Community Violence

In this study, 10% of youth (11% female and 8% male) felt unsafe at school or on their way to or from school at some point in the last 30 days. Nearly one in ten youth reported carrying a weapon within the last month and 12% reported they were threatened or injured with a weapon within the last year. A larger percentage of youth (42%) reported being in a physical fight during the past year and 11% of youth reported being a member of a gang

during the past year. Figure 9 shows a comparison of these data with 2007 NYC Youth Risk Behavior Survey information.

Current Dating Violence and Victimization and Other Violent Experiences

Youth who have experienced other violence as represented by the five violence questions (previously listed) have been victimized more frequently by dating violence. More than one-third of boys who report being victims of physical dating violence also reported carrying a weapon in the last 30 days, as compared to 18% of boys who are not in a violent

Table 5: Physical Dating Violence Victimization and Other Violence*

	Victims of Physical Dating Violence		Students in Nonviolent Relationships	
	Girls	Boys	Girls	Boys
Missing school due to the fear of violence in the last 30 days	16%	10%	10%	6%
Carrying a weapon in the last 30 days	11%	34%	6%	18%
Being threatened or injured with a weapon in the past 30 days	18%	32%	8%	18%
Participating in a fight in the past 12 months	68%	63%	37%	50%
Gang membership in the past 12 months	9%	29%	8%	18%

*Denominators based on youth who reported having a partner within the last year. The physical dating violence victimization scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI), and the community violence questions are based on the Youth Risk Behavior Survey (YRBS) questions. Denominators for girl victims ranged from 148 to 152, and for boy victims from 108 to 111, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 349 to 354 and for boys from 255 to 260, with ranges due to missing data on individual questions.

relationship. Similarly, a larger percentage of girls who are currently in a physically violent relationship reported missing school during the last month due to fear of violence than girls who are not in this type of relationship (16% vs. 10%).

Current Sexual Dating Violence Victimization and Other Violent Experiences

Nearly 20% of girls who reported currently being in a sexually violent dating relationship reported being threatened or injured with a weapon in the last year, compared to 10% of girls who are not currently experiencing this type of relationship.

A third of boys who report sexual violence victimization with their current partner also reported being a member of a gang at some point during the past year, compared to 18% of boys in nonviolent relationships. Similarly, nearly twice as many boys who are currently experiencing sexual violence from a dating partner report missing school because of fear for their safety (12% vs. 6%, respectively).

Current Physical Dating Violence Perpetration and Perpetration of Other Violence

Girls who report perpetrating physical dating violence against their partners also report a higher

Table 6: Sexual Dating Violence Victimization and Other Violence*

	Victims of Sexual Dating Violence		Students in Nonviolent Relationships	
	Girls	Boys	Girls	Boys
Missing school due to the fear of violence in the last 30 days	15%	12%	12%	6%
Carrying a weapon in the last 30 days	14%	41%	7%	19%
Being threatened or injured with a weapon in the past 30 days	20%	34%	10%	20%
Participating in a fight in the past 12 months	63%	61%	43%	52%
Gang membership in the past 12 months	9%	33%	5%	18%

*Denominators based on youth who reported having a partner within the last year. The sexual dating violence victimization scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI), and includes three questions on sexual violence (excluding forced kissing), and the community violence questions are based on the Youth Risk Behavior Survey (YRBS) questions. Denominators for girl victims was 56, and for boy victims ranged from 57 to 59, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 384 to 392, and for boys from 283 to 288, with ranges due to missing data on individual questions.

prevalence of other violence, with 61% reporting they have been in a physical fight within the last year compared to 34% of girls who do not perpetrate this violence. Likewise, boys who reported perpetrating physical violence against a partner had a higher prevalence across all the violence indicators, with 35% of those boys also reporting that they carried a weapon in the last month (compared to 21% of boys who did not report perpetrating physical dating violence), 32% reported being threatened or injured with a weapon in the last year (compared to 20% of boys who did not report perpetrating physical violence), and 30% reported being

a member of a gang (compared to 20% of boys who did not report perpetrating physical violence).

Current Sexual Dating Violence Perpetration and Perpetration of Other Violence

Sexual and physical dating violence perpetration are similar in that youth who report sexual violence perpetration also report higher levels of experiencing and perpetrating other forms of violence. For boys, sexual violence perpetrators reported greater rates of occurrences than boys who did not perpetrate this dating violence, in these areas: feeling unsafe at or going to and from school (14% vs. 6%),

Table 7: Physical Dating Violence Perpetration and Other Violence*

	<i>Perpetrators of Physical Dating Violence</i>		<i>Students in Nonviolent Relationships</i>	
	Girls	Boys	Girls	Boys
Missing school due to the fear of violence in the last 30 days	15%	11%	10%	7%
Carrying a weapon in the last 30 days	10%	35%	6%	21%
Being threatened or injured with a weapon in the past 30 days	16%	32%	7%	20%
Participating in a fight in the past 12 months	61%	60%	34%	53%
Gang membership in the past 12 months	8%	30%	9%	20%

*Denominators based on youth who reported having a partner within the last year. The physical dating violence perpetration scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI), and the community violence questions are based on the Youth Risk Behavior Survey (YRBS) questions. Denominators for girl perpetrators ranged from 220 to 223, and for boy perpetrators ranged from 61 to 63, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 278 to 284, and for boys from 302 to 308, with ranges due to missing data on individual questions.

carrying a weapon during the last month (36% vs. 21%), being in a physical fight during the last year (61% vs. 53%), and/or being a gang member (34% vs. 19%). Likewise, girls who report perpetrating sexually violent behavior against their partners also report higher levels (compared to girls who do not perpetrate sexual violence) for the following behaviors: missing school because they felt unsafe at or on the way to or from school (21% vs. 11%), carrying a weapon in the last 30 days (16% vs. 7%), and/or being threatened or injured with a weapon within the last year (21% vs. 10%).

Associated Factors for Dating Violence Perpetration and Victimization

The study examined the gender-specific relationships between the perpetration of sexual and physical dating violence and the perpetration or victimization of other violence behaviors. Controlling for age and race/ethnicity, girls who reported being in a physical fight within the past year were three times more likely to have perpetrated physical violence against a dating partner over the same timeframe than girls who report not being in a fight. Likewise, girls who report being threatened or

Table 8: Sexual Dating Violence Perpetration and Other Violence*

	<i>Perpetrators of Sexual Dating Violence</i>		<i>Students in Nonviolent Relationships</i>	
	Girls	Boys	Girls	Boys
Missing school due to the fear of violence in the last 30 days	21%	14%	11%	7%
Carrying a weapon in the last 30 days	16%	36%	7%	21%
Being threatened or injured with a weapon in the past 30 days	21%	27%	10%	21%
Participating in a fight in the past 12 months	57%	61%	45%	53%
Gang membership in the past 12 months	9%	34%	8%	19%

*Denominators based on youth who reported having a partner within the last year. The sexual dating violence perpetration scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI) and includes three questions on sexual violence (excluding forced kissing), and the community violence questions are based on the Youth Risk Behavior Survey (YRBS) questions. Denominators for girl perpetrators ranged from 43 to 44, and for boy perpetrators ranged from 53 to 55, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 457 to 464, and for boys from 310 to 316, with ranges due to missing data on individual questions.

injured with a weapon in the past year were almost three times more likely to perpetrate physical violence against their partner than girls who report not being injured or threatened.

For boys, carrying a weapon within the last 30 days was associated with perpetration of both physical and sexual violence against a dating partner in the last 12 months. Boys who report carrying a weapon were nearly three times more likely to have perpetrated physical violence and approximately two-and-half times more likely to have perpetrated sexual violence against their dating partner than boys who reported not carrying a weapon.

Gang membership was not a significant predictor of perpetration of *physical* dating violence for either boys or girls but was significant for the perpetration of *sexual* violence by boys against their dating partners—and also against boys by their partners. Boys who reported being a member of a gang during the last year were two times more likely to have perpetrated sexual violence against their dating partner and were also two times more likely to report having experienced sexual violence from their partner than boys who reported no gang membership.

How has sexual or dating violence affected you?

*“It made me feel so bad about myself
that I tried suicide.”*

—16-year-old female

Chapter 5: The Impact of Sexual and Dating Violence on Health

Sexual and dating violence have significant results on the health and wellbeing of young people. Immediate health effects include injury, but youth can also experience long-term health and psychological sequelae.

Sexual and Dating Violence Impact on Health: Brief Literature Review

Recent research has shown that youth who experience dating violence are at a higher risk for:

- having eating disorders,
- suicidal thoughts or attempts,
- lower self-esteem and emotional wellbeing,
- smoking, binge drinking, early initiation of drinking and cocaine use,
- risky sexual behaviors, such as noncondom use and having multiple sex partners, and
- pregnancy, when compared to youth who have not experienced dating violence.

References:

Ackard and Neumark-Sztainer, 2003; Gidycz *et al.*, 2008; Ackard, Eisenberg, and Neumark-Sztainer, 2007; Ackard, Neumark-Sztainer, and Hannan, 2003; Silverman *et al.*, 2001; Olshen *et al.*, 2007; Silverman, Raj, and Clements, 2004; Howard, Wang, and Yan, 2007; Howard and Wang, 2003; Eaton *et al.*, 2007; Coker *et al.*, 2000.

Limited research has focused on the health results on youth who perpetrate dating violence. Raj and colleagues (2007) conducted a qualitative study with adolescent male perpetrators of dating violence. Raj *et al.*, (2007) found that nonuse of condoms was more common in steady, often-abusive relationships, despite reports of high-risk sexual activity, including sexual infidelity and multiple sex partners. *Partners and Peers: Sexual and Dating Violence among NYC Youth* adds to this literature.

Youth who report experiencing nonpartner sexual abuse also report adverse health outcomes. A recent longitudinal study found that participants who reported sexual abuse in childhood and early adolescence were almost four times as likely to have inflicted self-harm (in the form of suicide attempts or self-mutilation) than participants with no history of sexual abuse (Noll *et al.*, 2003). Studies report that on average, sexual abuse victims start having voluntary sex significantly earlier than nonvictims, engaging in more high-risk sexual behaviors, including having multiple sex partners, using drugs and abusing alcohol, not using contraception, and trading sex for money or drugs (Population Information Program, 2000). The same report found that among women, victims of childhood sexual assault were twice as likely to be heavy consumers of alcohol and nearly three times as likely to become pregnant before the age of 18.

As this research indicates, there is a growing awareness regarding the health implications of dating and sexual violence on youth. Figure 10 shows the many associated health outcomes.

Figure 10: Health Outcomes of Partner Violence/Sexual Violence/Child Sexual Abuse*

Fatal Outcomes

Direct and Indirect

- Homicide
- Suicide
- AIDS-related
- Maternal mortality

Nonfatal Outcomes

Chronic Conditions

- Chronic pain syndrome
- Irritable bowel syndrome
- Gastrointestinal syndrome
- Fibromyalgia
- Somatic complaints

Physical Health

- Injury
- Physical symptoms
- Functional impairment
- Poor subjective health
- Permanent disability

Negative Health Behaviors

- Smoking
- Alcohol and substance use
- Sexual risk-taking
- Physical inactivity
- Over/undereating
- Ignoring preventive healthcare

Mental Health

- Posttraumatic stress
- Depression
- Anxiety
- Phobias/panic disorders
- Eating disorders
- Sexual dysfunction
- Low self-esteem
- Mental distress
- Substance-use disorder

Reproductive Health

- STI's/HIV
- Pelvic inflammatory disease
- Other gynecological disorders
- Unwanted pregnancy
- Unsafe abortion
- Pregnancy complications
- Miscarriage/low birth weight

* Figure based on the following sources: (1) PAHO factsheet, (2) Ellsberg and Heise (2005).

Table 9: Physical Dating Violence Victimization and Health*

	<i>Victims of Physical Dating Violence</i>		<i>Nonvictims of Sexual Dating Violence</i>	
	Girls	Boys	Girls	Boys
Reported low satisfaction with health	37%	16%	27%	14%
Reported low self-esteem	33%	19%	21%	17%
Reported high physical discomfort	41%	18%	27%	11%
Reported high to very high emotional discomfort	41%	14%	25%	9%

*Denominators based on youth who reported having a partner within the last year. The physical dating violence victimization scale is from the Conflict in Adolescent Dating Relationship Inventory, and the health questions are based on questions from the Child Health and Illness Profile—Adolescent Edition (CHIP—AE). Denominators for girl victims ranged from 128 to 152, and for boy victims ranged from 95 to 112, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 312 to 358, and for boys from 221 to 263, with ranges due to missing data on individual questions.

Table 10: Sexual Dating Violence Victimization and Health*

	<i>Victims of Sexual Dating Violence</i>		<i>Nonvictims of Sexual Dating Violence</i>	
	Girls	Boys	Girls	Boys
Reported low satisfaction with health	27%	20%	31%	14%
Reported low self-esteem	26%	18%	26%	18%
Reported high physical discomfort	52%	14%	28%	13%
Reported high to very high emotional discomfort	48%	15%	28%	10%

*Denominators based on youth who reported having a partner within the last year. The sexual dating violence victimization scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI), and includes three questions on sexual violence (excluding forced kissing), and the health questions are based on questions from the Child Health and Illness Profile—Adolescent Edition (CHIP—AE). Denominators for girl victims ranged from 56 to 67, and for boy victims ranged from 52 to 60, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 346 to 393, and for boys from 246 to 291, with ranges due to missing data on individual questions.

Youth Disclosure and Help-Seeking: What Research Shows

Data from an urban study of adolescent disclosure of sexual violence shows that 60% of adolescents who experienced rape or attempted rape disclosed this information to one or more individuals, whereas only 47% of those who reported experiencing coercive sex told someone about that encounter (Rickert, Wiemann, and Vaughan, 2005). A public-school study of rural high school students in North Carolina found that 60% of adolescent dating violence victims did not seek help (Ashley and Foshee, 2005). A study of young women in NYC found those seeking reproductive healthcare thought that health providers were the most appropriate adults to assist them with their experience of partner violence (Zeitler *et al.*, 2006).

Consistently, research has shown that adolescents are more likely to disclose sexual and dating violence experiences to their peers. According to the National Survey of Adolescents, young women whose unwanted sexual experience occurred between the ages of seven and 13 were more likely to tell an adult, while older adolescents were more likely to tell a peer (Krogan, 2004). Another study found that most victims of dating violence who sought help chose friends and family rather than professionals (Ashley and Foshee, 2005). A recent study of Latino ninth graders found that teens are more likely to seek help for a dating violence situation from informal sources of support, such as friends, than from formal sources such as healthcare professionals (Ocampo, Shelley, and Jaycox, 2007). This study found that students do not confide in or trust the adults in their social network. A Midwestern study of high school students found that not only do youth turn to their friends when they experience dating violence but they go to them for romantic-relationship problems as well (Weisz *et al.*, 2006).

What the Study Measured

For health outcomes, the study used the Child Health Illness Profile—Adolescent Edition (CHIP—AE) (Riley *et al.*, 1998), which measures include the following subscales:

- satisfaction with health,
- physical discomfort,
- self-esteem, and
- emotional discomfort.

The “satisfaction with health” scale includes questions on how the respondents rate their health in general, and a rating of health status. The “physical discomfort” scale examines how often in the past four weeks respondents have felt really sick, and specific symptoms they have felt, including fever or chills, dizziness, wheezing or trouble breathing, chest pain, headaches, stomach aches, and other symptoms that would result in physical discomfort. The “self-esteem” scale included the respondent’s agreements with the following statements: “I have a lot of good qualities,” “I have much to be proud about,” “I like being the way I am,” “I am satisfied with how I live my life,” and “I feel socially accepted.” The “emotional discomfort” scale assesses how often in the past four weeks the respondent had trouble falling asleep or staying asleep, trouble relaxing, being nervous or uptight, moody, irritable, or grouchy.

Partners and Peers: Research Findings

Current Partner Physical Violence Victimization and the Impact on Health

A similar relationship between physical dating violence victimization and health exists. Girls who reported physical violence in their relationships reported lessened health and self-esteem, with 37% reporting lower satisfaction with their health and 33% reporting low levels of self-esteem (compared to 26% and 21% of girls, respectively, who do not experience this violence). Boys who are victims in physically violent relationships also report higher emotional discomfort (14% vs. 10%) and physical discomfort (18% vs. 11%) than boys who are not experiencing this violence.

Table 11: Physical Dating Violence Perpetration and Health*

	<i>Perpetrators of Physical Dating Violence</i>		<i>Nonperpetrators of Physical Dating Violence</i>	
	Girls	Boys	Girls	Boys
Reported low satisfaction with health	34%	14%	26%	15%
Reported low self-esteem	27%	19%	22%	17%
Reported high physical discomfort	36%	18%	27%	12%
Reported high to very high emotional discomfort	36%	19%	24%	9%

*Denominators based on youth who reported having a partner within the last year. The physical dating violence perpetration scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI) and the health questions are based on questions from the Child Health and Illness Profile—Adolescent Edition (CHIP—AE). Denominators for girl perpetrators ranged from 199 to 224, and for boy perpetrators ranged from 53 to 64, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 213 to 287, and for boys from 263 to 311, with ranges due to missing data on individual questions.

Table 12: Sexual Dating Violence Perpetration and Health

	<i>Perpetrators of Sexual Dating Violence</i>		<i>Nonperpetrators of Sexual Dating Violence</i>	
	Girls	Boys	Girls	Boys
Reported low satisfaction with health	27%	16%	30%	15%
Reported low self-esteem	29%	15%	24%	18%
Reported high physical discomfort	48%	15%	29%	12%
Reported high to very high emotional discomfort	27%	12%	29%	11%

*Denominators based on youth who reported having a partner within the last year. The sexual dating violence perpetration scale is from the Conflict in Adolescent Dating Relationship Inventory (CADRI) and includes three questions on sexual violence (excluding forced kissing), and the health questions are based on questions from the Child Health and Illness Profile—Adolescent Edition (CHIP—AE). Denominators for girl perpetrators ranged from 38 to 45, and for boy perpetrators ranged from 50 to 56, with ranges due to missing data on individual questions. Denominators for girls in a nonviolent relationship ranged from 402 to 466, and for boys from 266 to 319, with ranges due to missing data on individual questions.

Current Partner Sexual Dating Violence Victimization and the Impact on Health

The impact of sexual dating violence victimization on health is very high. Nearly half (48%) of all the girls and 15% of the boys who report being sexually victimized in their dating relationship also reported high to very high emotional discomfort (compared to 28% of girls and 10% of boys who are not sexually abused in relationships). These youth encounter physical symptoms associated with experiences of sexual dating violence, with more than half of all girls (52%) and 14% of boys reporting average to high physical discomfort. Also, boys who report sexual dating violence victimization additionally report lower satisfaction with their health overall, when compared to boys who do not experience this victimization.

Current Partner Physical Violence Perpetration and the Impact on Health

Girls who reported perpetrating physical violence against their dating partner report lower levels of self-esteem and wellbeing on every health indicator, with a third reporting low satisfaction with health, more than a quarter (27%) reporting low levels of self-esteem, and more than a third reporting both average to high physical discomfort (36%) and high to very high emotional discomfort (36%). Boys who report perpetrating physical violence against their partner were nearly twice as likely to report high to very high emotional discomfort when compared to boys who did not (19% vs. 9%).

Table 13: Adjusted Odds Ratios (95% Confidence Intervals) of Functional Health Status Indicators*

Dating Violence	Fair to Poor Health Status	High Emotional Discomfort	High Physical Discomfort
Physical Violence			
Current Victim		1.7 (1.1, 2.5)	1.7 (1.2, 2.4)
Current Perpetrator		1.7 (1.1, 2.5)	---
Ever Victim		1.9 (1.2, 2.8)	1.8 (1.3, 2.7)
Sexual Violence			
Current Victim	2.6 (1.4, 4.8)	1.9 (1.2, 3.3)	2.2 (1.4, 3.9)
Current Perpetrator	2.6 (1.3, 5.1)	---	1.8 (1.1, 3.0)
Ever Victim		1.7 (1.1, 3.0)	2.5 (1.4, 4.2)
Both Physical and Sexual Violence			
Current Victim		2.8 (1.5, 5.1)	2.4 (1.1, 4.4)
Current Perpetrator		2.0 (1.1, 4.0)	---
Ever Victim		2.8 (1.5, 5.2)	3.7 (2.0, 6.9)

*Data presented at the 2008 Society for Adolescent Medicine Conference: Rickert *et al.*, 2008. Data is based on youth who reported having a partner within the last year, with (current victim or current perpetrator) questions from CADRI, and youth who reported ever having a dating relationship (ever victim), questions from the DVI. The health scales are based on questions from the Child Health and Illness Profile—Adolescent Edition (CHIP—AE).

Current Partner Sexual Violence Perpetration and the Impact on Health

Youth who report dating violence perpetration experience effects on health and wellbeing. Boys who report perpetrating sexual violence against their dating partner reported a lower satisfaction with their health and higher emotional discomfort than boys who did not perpetrate this violence. Likewise, girls who are sexually violent to their partners reported lower levels of self-esteem and reported higher levels of physical discomfort more often than girls who did not report perpetrating this violence.

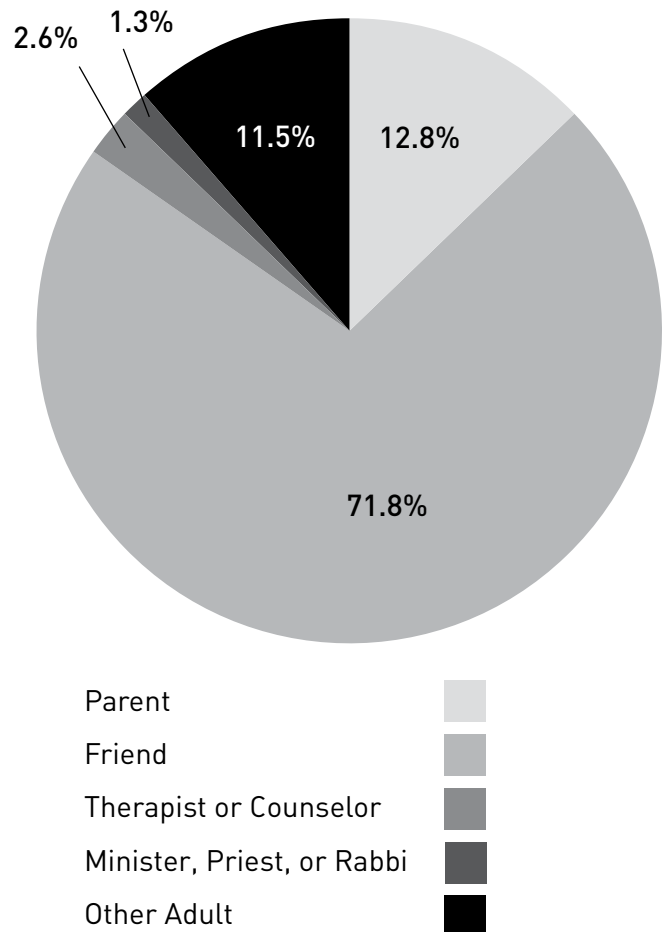
Nonpartner Sexual Violence Victimization and the Impact on Health

Nonpartner sexual violence has an impact on health. In this study, girls who reported experiencing nonpartner sexual violence report lower satisfaction with their health twice as often (44%) than girls who reported not experiencing this violence (26%). Boys who experienced sexual abuse also reported lower satisfaction with their health (29%). Nearly half (46%) of all girls and more than a quarter (26%) of all boys who reported a history of nonpartner sexual violence reported average to high physical discomfort.

“Sexual violence has affected me, emotionally and physically. I’m doing better now, but it’s hard to trust people.”
—15-year-old female

The study found that youth who experienced non-partner sexual violence scored lower on measures of wellbeing and self-esteem. Forty-one percent of girls and 35% of boys with a history of nonpartner sexual violence reported lower levels of self-esteem as compared to 22% of girls and 20% of boys who did not report a history of this violence. Similarly, 42% of girls and a quarter of boys who reported having experienced sexual abuse reported higher levels of emotional discomfort compared to only 23% of girls and 8% of boys who did not report this history of violence.

Figure 11: Person Youth First Tell about Their Experiences with Dating Violence*



* Data based on (133) youth who self-identified as having experienced sexual or dating violence.

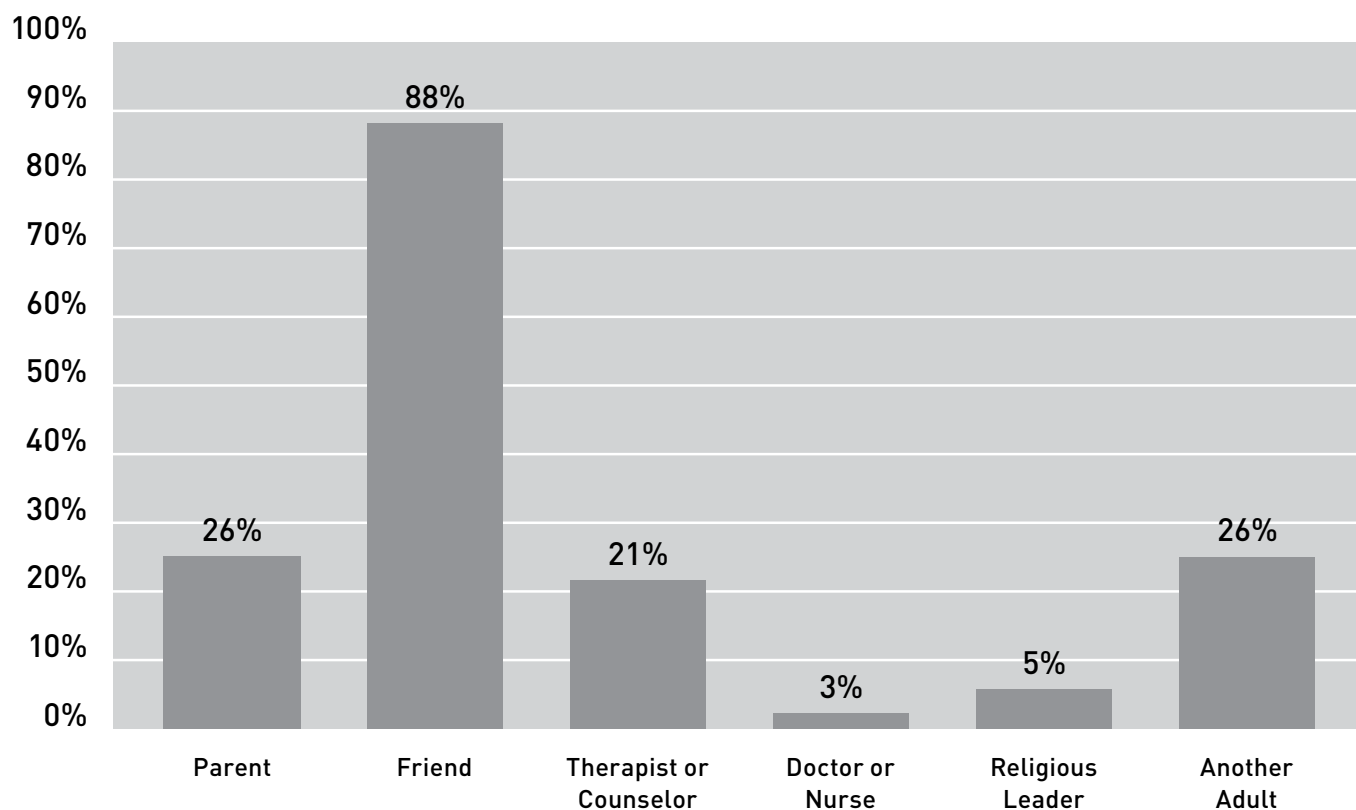
Dating Violence Victimization and Associated Health Factors

Multivariate analyses, controlling for potential confounders, such as gender, ethnicity, country of birth, and history of child sexual abuse demonstrated that perpetration or victimization of dating violence was associated with three of four health outcomes. That is, high levels of emotional and physical discomfort were significantly associated with being a victim of either physical or sexual violence in the last year, as well as among those who reported a lifetime history of physical and/or sexual victimization. Youth who reported lifetime sexual *and* physical dating violence victimization were nearly four times more likely to report having high physical discomfort. In addition, youth who reported being victimized by sexual dating violence in the last year were nearly three times more likely to report a poorer health status than youth who had not experienced this violence.

Dating Violence Perpetration and Associated Health Factors

Those who perpetrated dating violence also experienced adverse health outcomes. Youth who reported perpetrating sexual violence in the last year were two-and-a-half times more likely to report poorer health status than youth who did not report perpetrating violence. Those who reported perpetrating sexual violence directed toward a dating partner in the past year were almost two times more likely to report high levels of physical discomfort than those who did not. Youth who perpetrated sexual violence did not have an increased risk of emotional discomfort, but youth who reported perpetrating physical dating violence did, and were nearly two times as likely to report higher emotional discomfort than those who did not report perpetrating violence. These data demonstrate the critical role various types of dating violence independently contribute to the reporting of functional

Figure 12: Youth Dating Violence Disclosure*



* Data based on (133) youth who self-identified as having experienced sexual or dating violence.

health status among adolescents. Future research should explore these connections.

Telling Someone and Getting Help

A smaller percentage of youth identified themselves as having experienced physical or sexual violence than those identified through the series of behavior-specific questions. This means many youth do not identify themselves as having been “abused” or a victim of dating violence. Of those who did identify themselves as victims of dating violence, 59% told someone about their experience. Of those who did tell, 34% told someone about the physical violence from a partner, 11% told someone about sexual violence from a partner, and 14% told someone about experiencing both physical and sexual violence from their partner.

How has dating violence affected you?

“It has affected me because I know some people my age that are in a violent relationship and it bothers me a lot.”

—17-year-old male

Youth who did tell someone did so quickly, with 30% telling someone on the same day it occurred and 12% telling someone within two days. Only 14% of youth told someone more than a year after the violence occurred. Youth also reported telling many people about the violence. For those that did tell, they told an average of three people ranging from some who only told one person, to one youth who told 25 people.

Who are youth telling about the violence they are experiencing in their dating relationships? Overwhelmingly, 72% told their friends *first*, while 13% told a parent first.

After telling a friend, many youth (51%) go on to tell more friends. Overall, 88% told a friend about the violence and one-quarter told a parent. Twenty-two percent of youth told a therapist or counselor, 3% a doctor or nurse, 5% a religious leader, and 26% another adult. Nearly one in five youth who told someone reported seeking help from a health professional, teacher, or guidance counselor.

“We knew it would be a valuable study that would provide us with a great deal of information about our students. Once we saw the results, we shared them with the entire school community because it was important to educate everyone about the problem.”

—participating school principal

Chapter 6: From Research to Action

The frequency of sexual and dating violence among youth presented in this report requires action on many levels: from administrators, students, parents, teachers, health professionals, and youth—as well as city leaders. The study’s recommendations follow a two-pronged strategy: ending sexual and dating violence among NYC youth and providing appropriate response to those that have already experienced this violence. It is essential that both of these occur in order to address the scope of sexual and dating violence.

Prevention of Sexual and Dating Violence

Prevention Framework

The New York City Alliance Against Sexual Assault has developed a prevention framework in order to end sexual violence in New York City. The Alliance will develop prevention programs as well as assist other organizations in developing programs that are:

- **Focused on Norms Change:** Borrowing from the social ecological framework (see text box: The Social Ecological Model), the Alliance believes environment influences behavior, and that in order to successfully prevent sexual and dating violence, the Alliance needs to address the *norms* that are conducive to, or tolerant of this violence. Norms are a key mechanism by which institutions and organizations shape behaviors, positively and negatively (Fujie Parks, Cohen, and Kravitz-Wirtz, 2007). Norms are standards or unspoken rules that are socially enforced and provide a model for behavior. Sexual and dating violence will not end unless the prevailing norms of socialization and acceptance of this violence are challenged and changed.
- **Comprehensive and Multidisciplinary:** No single program will end sexual and dating violence. The Alliance believes in using a spectrum or continuum of activities that are aimed at individual-, community-, and systems-level change. This requires participation from multiple sectors and stakeholders.

The Alliance turned to the *Spectrum of Prevention* model developed by the Prevention Institute (Cohen and Swift, 1999).

- **Participatory:** Systematic changes are impossible without active community involvement. The Alliance has adopted Participatory Action Research (PAR) as the path toward the critical next step in reaching out to communities that are underserved in these systems in order to create new partnerships and collectively work toward ending sexual and dating violence in New York City. The PAR process includes meaningful community involvement in all phases, power-sharing between program staff and the community, mutual respect and bidirectional learning from everyone involved, and a focus on action (White, Suchowierska, and Campbell, 2004).
- **Engaging Community Leaders as Agents of Change:** Following “the norms” approach, there are key champions and leaders that represent the “tipping points” to changing social norms. These people are respected and looked up to in their communities and are key allies in ending sexual violence. The Alliance uses community mobilizing to actively engage and further develop the leadership of these champions to prevent sexual and dating violence.
- **Stage-Specific:** The Alliance believes that communities are in different stages of readiness for primary prevention. Community readiness is the degree to which a community is prepared to take action on a particular health or social issue (Oetting *et al.*, 1995). Interventions must be challenging enough to move a community forward, but efforts that are too ambitious are likely to fail because community members will not be able to respond (Plested *et al.*, 2005). It is important to be clear that the concept of community readiness is not that some communities *are* ready while others are *not*. Rather, communities differ in the degree to which they are ready for action. If a community is at a very low level of readiness, then direct efforts, such

The Social Ecological Model

Individuals are influenced by their environments, and at the same time, an environment is shaped by its individuals. The social ecological model developed by Urie Bronfenbrenner in the 1970s emphasizes this constant interaction between individuals, the environment, and the layers in between. This model can also be applied to understand the factors important in sexual violence prevention.

Individual-level influences are biological, and include personal history factors that increase the likelihood that an individual will become a victim or perpetrator of violence. For example, hostility toward women, childhood history of sexual abuse, or witnessing family violence (among other factors) may influence an individual's behavior choices that lead to perpetration of sexual violence (CDC, 2004).

Relationship and group-level influences are factors that increase risk as a result of relationships with peers, intimate partners, and family members (CDC, 2004). Research has shown that social norms upheld by friends, family, and partners influence behavior (Fujie-Parks, Cohen, and Kravitz-Wirtz, 2007).

Community-level influences are factors that increase risk, based on social environments, and include an individual's experiences and relationships with schools, workplaces, and neighborhoods.

Societal-level influences are larger, macro-level factors that influence sexual violence, such as gender inequality, religious or cultural belief systems, societal norms, and economic or social policies that create or sustain gaps and tensions between groups of people (CDC, 2004).

Interactions can occur within a particular system or across systems. Most often, these interactions occur in a top-down manner; environment influences individual behavior. Yet, interactions can also occur in the opposite direction. Individuals can be instrumental in forming alliances or coalitions to enact change within their community and/or society. Furthermore, other factors, such as technology, can move in both directions.

The social ecological model allows one to examine various factors that explain individual behavior, and calls for prevention strategies that include activities affecting and targeting multiple levels of this model.

as awareness-raising campaigns, will need to be made to improve the level of readiness. If a community is at a mid- or high level of readiness, then that community can begin designing an action agenda. All prevention work begins with community-based readiness assessment.

- **Solution-Based and Positively Focused:** The Alliance envisions a city without sexual and dating violence. Prevention work is grounded in promoting a positive set of behaviors through the creation of environments and norms that promote those behaviors, instead of focusing solely on eliminating negative behavior. The outcome of this prevention work is seen as building healthy behaviors and communities. The Alliance understands the importance of working with communities to clearly define what the term *healthy* means.

- **Integrated and Collaborative:** Many social movements are focused on changing social norms and behaviors. The norms that allow sexual and dating violence to continue in NYC also allow for other unhealthy behaviors and norms (such as behaviors that lead to HIV transmission, general violence, bullying, hate crimes, etc.). Instead of creating separate prevention movements, the City should work together to comprehensively change the social norms that affect these behaviors. The Alliance believes in working across sectors, and using—as well as sharing—best practices and knowledge with allies in other movements.

Programmatic Recommendations

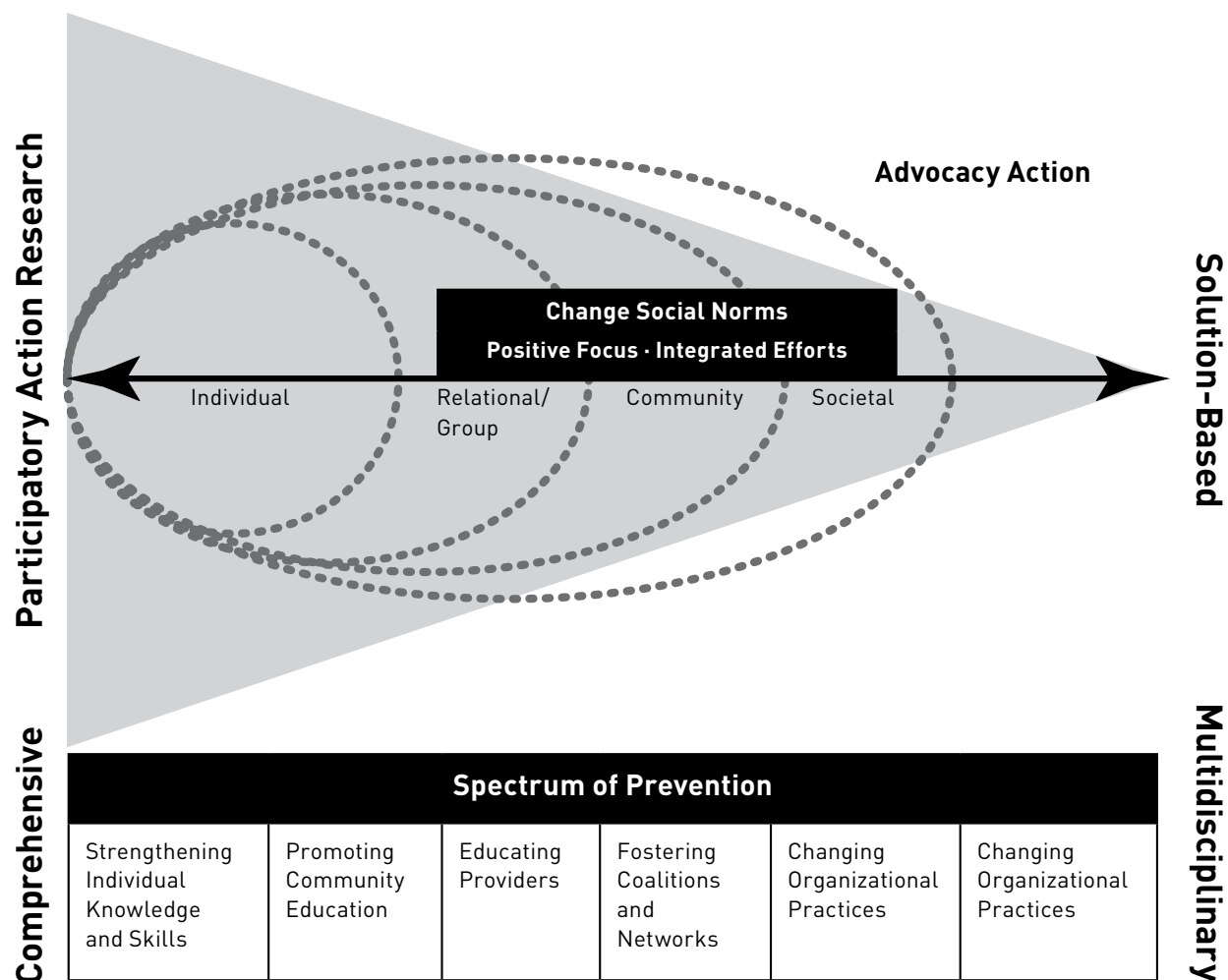
This study provides data to inform prevention programming. Based on this data, the Alliance recommends that:

- **Schools and programs that work with youth should include a focus on primary prevention.**

Primary prevention focuses on examining and addressing the root causes of violence such that violence can end *before* it occurs.

- **Prevention efforts should work with and develop youth leaders as an impetus for change.** Since youth often turn to friends in times of crisis, it is important to develop leadership among youth to address the root causes of sexual and dating

Figure 13: NYC Alliance Against Sexual Assault Violence Prevention Framework



violence and challenge accepted peer norms. The Alliance’s Youth Action Council is one example of building youth leadership (see text box: Youth Action Council on page 70).

- **Prevention efforts should include a strong focus on changing social norms.** This can happen by focusing prevention efforts at the community level, such as schools and peer networks. By focusing on changing community norms, the underlying factors that influence violent behaviors can be changed.
- **Prevention programming must include the term “sexual violence” in the definition of “dating violence,” and vice versa.** This research shows that sexual violence is a component of dating violence. Many dating violence prevention efforts only

address physical violence, but these efforts will not end dating violence if they fail to address a key component of dating violence—sexual violence. The sexual and dating violence prevention movements should work together to ensure comprehensive dating violence prevention efforts.

- **Prevention efforts should be integrated and collaborative with other health efforts.** This study shows the impact of dating violence on the health of young people. Often health programs such as those that seek to reduce teenage pregnancy, HIV transmission, and others are seeking to address the same social norms as the dating violence prevention programming. Working together ensures comprehensive prevention programs for youth.

Youth Voices:

What Should Schools Do to Reduce or Prevent Sexual or Dating Violence?

"Have sexual and dating violence classes and programs in the school."

—17-year-old female

"Give class and information about it. And even have a school night about it. Or a special day."

—16-year-old female

"Give out info on it and make students feel comfortable with the school workers so they can open up to them."

—16-year-old male

"Counseling and scheduled one-on-one conferences with students."

—17-year-old male

"Have more young counselors so the teens can talk to them."

—17-year-old female

"Have groups with an equal amount of men and women and just let them come up with their own issues and talk about it."

—18-year-old male

"Have a program where you can speak to a counselor or a group of peers that are also living through the same experience."

—17-year-old male

"Have a sex-ed class. Not just about having sex, but signs of an abusive man or partner."

—19-year-old male

"Hold workshops to have people who had been a victim of abuse come in and talk to them and show them the results that can happen to them if they don't get help and come out of the relationship."

—17-year-old female

"I don't believe that they can do anything unless the student tells them or they see it, but in general maybe they could have class discussions about it so that maybe someone who is going through it can tell the staff."

—16-year-old female

"I think all the school can do is inform us on centers to provide a place where they can open up and express themselves and find a way to stop or prevent the sexual or dating violence."

—18-year-old male

"I think more schools should have workshops on sexual or dating violence to keep teens aware of the differences between someone loving you and trying to control and abuse you."

—18-year-old female

"I think that schools are doing a good job on having workshops about how to prevent this, it's just that teens say that they love their partners and they are afraid that their partner may leave them."

—18-year-old female

"Speak out about it don't keep it in the closet. People be knowing what's going on."

—19-year-old male

"Just keep giving us advice, speak about experiences they know about, and not give up on us."

—17-year-old female

• **Violent behaviors among youth can be the entry point for discussions about teen sexual and dating violence.** This study shows that youth who perpetrate or are victims of violence are at a higher risk of being involved (either as a perpetrator or victim) in teen sexual and dating violence. These violent behavior indicators should serve as an entry point for discussion with youth about their dating relationships. Likewise, addressing teen sexual and dating violence may also reduce other violent behaviors.

• **Health professionals should talk to adolescents about sexual and physical violence.** These discussions about sexual and physical violence can be both primary and secondary prevention of sexual and physical violence. It serves as primary prevention in that it changes the social norms around privacy and begins to start the dialogue on sexual and dating violence in the healthcare setting. It serves as secondary prevention in that it can potentially reduce the likelihood of revictimization. This study found that youth who experience nonpartner sexual violence are at an increased risk of experiencing dating violence. If these youth are asked about their nonpartner sexual violence and referred to services, this may potentially prevent them from getting into violent dating relationships.

Appropriately Responding to Sexual and Dating Violence

This study also provides rich data on victimization and experiences of young people. Based on this data, the Alliance makes recommendations for responding to young people who have already experienced sexual or dating violence.

Teens should have access to youth-friendly, culturally appropriate, and language-appropriate referral information. Given that teens disclose incidents of sexual and dating violence to friends first, providing them with referral information is key to helping them support each other and reducing the stigma around sexual and dating violence. One such resource that the Alliance developed is the NYC Teen Health Map: a subway map on one side and a youth-friendly referral guide on the other, which folds into a discreet card to be tucked into

the wallet. The referral guide includes information for those who may have experienced sexual violence, hotlines to call, free counseling, and healthcare centers in each of the five boroughs (see text box: NYC Teen Health Map on page 72).

School personnel and others who work with youth should be trained on how to properly handle disclosures and service referrals. Since many youth who have experienced sexual and dating violence tell someone about that violence, it is imperative that all those who work with young people are trained in how to properly handle disclosures and how to refer youth to services. Proper responses to disclosures of sexual and dating violence require that sensitivity and respect be given to the survivor. This training should be inclusive of several audiences: youth workers, including after-school program staff; school staff, including principals, teachers, guidance counselors, nurses, security guards, and janitors (among others); and healthcare professionals. This means that appropriate policies and procedures must be implemented in these settings.

If a teen discloses dating violence, counselors should inquire about histories of physical and sexual violence victimization. If the teen is seeking counseling for dating violence, it is important to explore histories of nonpartner sexual violence as well as to provide the most comprehensive care. Likewise, if the teen is seeking counseling for nonpartner sexual violence it is important to ask about violence within dating relationships.

Health professionals should speak with adolescents about sexual and physical violence. This study expanded on the growing body of literature that shows the connections between sexual and physical violence and adverse health outcomes. These associations highlight the importance of talking about sexual and relationship violence during youth healthcare visits. Healthcare professionals, when assessing the health of teenagers, must consider the role both current sexual and dating violence and past sexual abuse play in contributing to the presentation and exacerbation of physical and emotional symptoms.



Youth Action Council

Including young people's perspectives is an integral part of the Alliance's goal to develop effective prevention and response programs for sexual violence and dating violence amongst youth. With the development of a Youth Action Council (YAC) composed of New York City youth ages 14 to 21, YAC members play a vital role in the Alliance and other allied organization's advocacy and research projects by providing ideas and feedback about youth and youth's needs. YAC assists program planners to better understand the concerns and priorities of young people, their families, and their communities.

The development of the YAC has been guided by a participatory and skill development approach that emphasizes involving young people in decision-making and leadership. Not only do YAC build skills among its members, but their involvement encourages civic responsibility and community service, helping young people feel valued by addressing issues important to them.

Youth input was a crucial component to the development of the YAC. The Alliance held two preliminary meetings with youth in May 2007 to identify issues of concern and to gather data on

the most effective ways to involve youth as members of the YAC. From these meetings, youth emphasized that topics of concern amongst their peers were date rape, behavior in relationships, how to help those who have

I wanted to be a part of YAC because I find sexual assault a serious problem all over the world and I'd like to help the cause.

—Mahfug Hossain, 17-year-old male YAC member

experienced sexual violence, how to prevent the abuse from occurring, and the role of pop culture in these issues. Young people highlighted that they want to be part of the YAC because they can make a difference in the lives of their peers, because they want to help end sexual violence amongst youth, they want to voice teens' concerns, and they want to raise awareness about these issues.

Through Youth Action Council meetings, youth have learned about primary prevention of sexual violence, or identifying the root causes of that violence. One such activity that has helped us explore with youth the root causes of and solution to sexual violence is the 'problem tree' activity. Through this activity, youth can examine the root causes of sexual violence (the roots of the tree), the effects of sexual violence (the leaves) and what can be done to change the situation and who can help (the flowers and fruit).

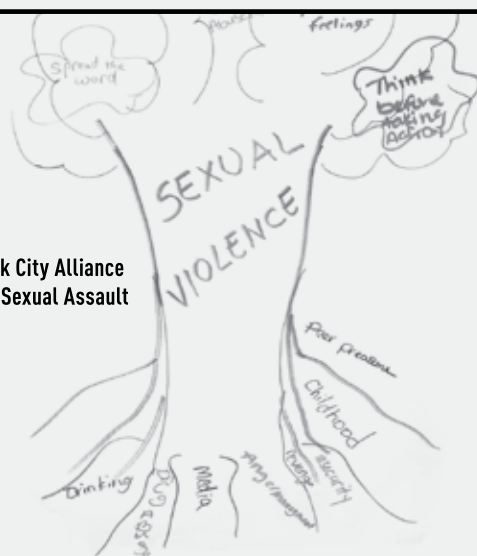
Youth are gaining valuable skills and peer-to-peer education from involvement in the YAC. The Alliance believes that New York City has the ability to overcome youth dating and sexual violence. Our Youth Action Council is in a prime position to help us improve the lives of youth through empowerment and education.

I wanted to be a part of YAC because it will help be a way to not only voice certain issues amongst teens, but also a way to help find solutions. I have always had an interest in solving different problems, but sexual violence is one that is more prominent today and grabs my attention more than others due to the increase in sex and sexual assault amongst teens. I think people, including myself, need to become more aware of the consequences of their actions and the issues of today. I think this is also a great opportunity for me to further build my leadership skills while gaining new ones.

—Anastasia Ramirez, 17-year-old female YAC member



New York City Alliance
Against Sexual Assault



Youth Voices:

What Do You Think Would Reduce Sexual or Dating Violence in the Lives of Teens?

*"A better understanding of one another.
To know where the relationship stands."*

—17-year-old male

*"I think more parents should talk to teens
about sexual or dating violence."*

—17-year-old female

*"Being able to talk to your partner without
being violent when you hear something
that you don't want to hear."*

—18-year-old male

*"Books or TV shows that shows what
really happens to people so they could
see what is really going on..."*

—18-year-old male

"Dating within your own age group."

—18-year-old male

*"Get to know the person before you get
in a relationship with them. Also you need
to respect yourself enough not to settle
for some dumb ass."*

—19-year-old male

*"I think that if teens tell how they REALLY
feel to their partner, they would feel less
scared or not scared at all, and if teens
talk sooner about someone hurting them
or abusing them they could stop it before
it gets out of hand."*

—17-year-old female

*"I think that strong communication, trust,
and lots of support between people can
help reduce sexual or dating violence.
Also, I feel that information should be
everywhere, in case people do need help."*

—18-year-old male

*"I think what would reduce sexual or
dating violence in teens are less fights,
because less fights would cause
less violence, depending on how bad
the situation is or how they handle
the situation."*

—17-year-old male

*"If teens are given more information
about this topic."*

—18-year-old female

"If their parents become more involved."

—18-year-old male

*"If they had more help and advice,
as in someone they can go to and talk
to without being judged by what they say
and go through in their relationship or
life. Someone outside the family
who won't tell their parents/guardian."*

—17-year-old female

"If they had more people to turn to."

—18-year-old female

*"If they knew what was going on before
they just jumped into a relationship think-
ing they're grown and take the time to see
what they are worth and they
deserve better."*

—18-year-old male

*"I'm not even sure but I think that more
sex education in schools should help..."*

—19-year-old female

NYC Teen Health Map

It's real sad 'cause I do know girls that have been raped in the past. They don't tell anyone, they don't tell the authorities, they feel ashamed or they think it's their fault. Sometimes it's like things happened in the past and it's too late and you should have told your mom or gone to the police. That's why I wanted to participate 'cause I could sort of relate. It's part of trying to get information out to people who've been raped or abused.

—17-year-old male focus group participant that helped develop the NYC Teen Health

The New York City Alliance Against Sexual Assault initiated a series of teen focus groups in 2006 to determine an effective means for developing and distributing resource information to young people. Youth emphasized that the more functional and practical the product, the more likely they are to keep it and use it in the future. The Alliance used this information to develop the NYC Teen Health Map, a foldable pocket subway map on one side and comprehensive adolescent-friendly services resource guide on the back.

"You might know somebody who is in a situation and you can actually help them. It can happen to you, it can happen to anybody and you can give it [the NYC Teen Health Map] to them."

—16-year-old female

After its distribution to four high schools and several youth-serving organizations in NYC in the fall 2006, the Alliance conducted a qualitative evaluation of the Map's utility and appeal to the youth that received the map and gathered youth input about revisions that should be made.

I like that it gives you a bunch of places that you can go and then if you see one that is close to where you live you just turn the map and 'oh! It's right here!'... I can take this train or this.

—15-year-old male

It's good because it's easy to take it anywhere.

—14-year-old female

Based on findings from the evaluation, the NYC Teen Health Map was revised, reprinted and distributed to youth across the city. Since youth are most likely to turn to their friends if they have experienced sexual or dating violence, it is important that youth have these maps both for themselves and to give to their friends.

Yes, I would [carry it with me] and it would be nice to have more to hand them out to friends because they are small and they can fit in your wallet.

—15-year-old male



To order NYC Teen Health Maps call the NYC Alliance Against Sexual Assault at **212.229.0345**

NYC Alliance Against Sexual Assault
27 Christopher Street, 3rd Floor
New York, NY 10014
212.229.0345 phone
212.229.0676 fax
www.nycagainstrape.org



**New York City Alliance
Against Sexual Assault**

Table 14: Overview of Recommendations by Key Findings

Recommendations			
	Prevention	Response	Future Research
Sexual and dating violence is prevalent among NYC youth.	Schools and programs that work with youth should include a focus on primary prevention.	Teens should have access to youth-friendly referral information such as the New York City Teen Health Map.	Research should focus on identifying the root causes of youth sexual and dating violence.
Youth experience sexual violence from people they know.	Prevention efforts should be focused on norms change by addressing the norms that are conducive to, or tolerant of, sexual and dating violence. This can be done by focusing prevention efforts at the community level.	School personnel and others who work with youth should be trained on how to properly handle disclosures including confidentiality and reporting issues and also how and where to refer youth for help.	Future research should explore who is perpetrating sexual violence and what are the underlying norms that are enabling and supporting this violence in society.
Youth tell their friends first, if they tell anyone at all about the violence.	Schools and programs that work with youth should include a focus on primary prevention. An additional recommendation is to develop youth leaders as agents of change.	Resources such as the New York City Teen Health Map should be distributed to youth to help them support their friends.	More research should examine what advice teens are giving to their friends about sexual and dating violence.
Dating violence is often inclusive of both physical and sexual violence.	Prevention programming must include sexual violence in their definitions of dating violence and focus activities on preventing sexual violence within teen relationships.	If a teen discloses dating violence, counselors should inquire about both histories of physical and sexual violence victimization.	More research should be paid to developing tools to measure sexual dating violence.
Youth experience adverse health outcomes as a result of dating violence.	Primary prevention programming should be integrated and collaborative with other health programming.	Primary care providers and other health professionals should talk to adolescents about sexual and dating violence.	Future research should focus on the long-term health effects of sexual and dating violence.
Perpetrating other forms of violence is a risk factor for dating violence perpetration.	School counselors should utilize perpetration of other violence to begin talking with teens about violence in their dating relationships and by people they know.	School staff and other professionals should be trained on how to properly handle disclosures and refer youth to services.	Future research should focus on exploring the connection between gang membership and sexual dating violence perpetration among young males.
Youth who experience nonpartner sexual violence are at an increased risk of being a victim of dating violence.	Secondary prevention should be addressed by health professionals who work with youth screening for sexual violence and referring youth to services.	School staff and other professionals that work with youth should be trained on how to properly handle disclosures and refer youth to services.	Future revictimization research should focus on the links between nonpartner sexual violence and future physical dating or domestic violence.
Youth who experience nonpartner sexual violence frequently experience chronic abuse.	Prevention efforts should be focused on norms change by addressing the norms that are conducive to, or tolerant of, sexual and dating violence. Specifically, there should be an examine of societal and community norms that support child sexual abuse.	School staff and other professionals that work with youth should be trained on how to properly handle disclosures including when and how to report violence and refer youth to services.	More research should be focused on the social norms that contribute to child sexual abuse perpetration.

“Conflict and violence in dating relationships is a large problem in our city, and in my school, and it is imperative to better understand how we can help our young people maintain healthy relationships.”

—participating school principal

Appendix A: Methodology

This study was carried out by the New York City Alliance Against Sexual Assault and the Columbia Center for Youth Violence Prevention (CCYVP) at the Mailman School of Public Health at Columbia University. Initial outreach was conducted with schools to participate in the study. Four schools were selected through convenience sampling (three in Manhattan and one in Brooklyn) and the superintendents and school principals provided written approval for the study. Youth in grades nine through twelve at these four schools were invited to participate and the overall participation rate was 70%.

This study was approved by the three Institutional Review Boards at St. Luke's-Roosevelt Hospital (the NYC Alliance Against Sexual Assault's home IRB at the time of the study), Columbia University, and the NYC Department of Education.

Formative Research

Both partners came to this study with a background in sexual and dating violence research. The Alliance conducts primary research and is the leading organization in applying research to practice in New York City. The Alliance focuses its research on providing best care and on understanding the prevalence and nature of sexual violence in NYC. The Alliance has worked on two previous studies on the topic of sexual violence among youth. First, the Alliance developed and evaluated a prevention poster geared toward young men ages 11–13. This poster was evaluated in several after-school programs in NYC. For the development of the poster, the Alliance conducted extensive research on the key developmental issues facing youth and the context through which young men understand sexual violence. Second, the Alliance has conducted a systematic review of national and citywide literature on the prevalence of sexual violence among high school age youth.

Similarly, CCYVP has a history of focusing on violence prevention. One of the core projects during

the first five years of the Columbia Center for Youth Violence Prevention was researching approaches to addressing dating violence. Its most recent study surveyed 638 young women between 15 and 24 at a large family-planning clinic serving all five NYC boroughs (Davidson, 2004). This was a cross-sectional, quantitative study that provided important information about the experiences of young women in NYC, but it was beyond the scope of the project to investigate the circumstances in which violence occurred, the sequence of events, or the severity or consequences of the violence. Since the sample was all female, there was no information on the perceptions and experiences of young men. In addition, the sample was taken from young women seeking reproductive healthcare, and therefore there was no reference population against which to estimate prevalence. In order to plan appropriate interventions the organizations need to know more about the pathways to violence, and whether there are characteristics that differentiate patterns of violence or protect young people from violence.

Sampling and Subject Selection

This study utilized a multisite, cross-sectional, population-based survey design to examine sexual and dating violence among youth. The study was conducted in four public high schools in New York City. All students enrolled at the four schools were invited to participate in the study.

Initial outreach to fifteen high school principals across the five NYC boroughs was conducted over a four-month period from August to November 2005. Many high school principals were unable to participate due to the study's timing and current workload. Four schools expressed interest in participating and were chosen for this study. In addition, one school was classified as an alternative transfer high school, meaning students must be at least 16 years old and have attended another high school prior to enrolling in the transfer high school.

The transfer high school provides students with an opportunity to earn their high school diploma in a smaller, student-centered learning community. Thus, this was a sample of convenience rather than a representative or random sample.

This study uses a passive parental consent and active student assent structure. A parent letter was developed to explain the study and mailed from each of the four schools on researcher letterhead to all parents/legal guardians. The schools' staff mailed all materials in order to preserve the confidentiality of the students' home addresses. All materials were printed on the researcher's stationery and did not include any endorsement by the school principal or staff.

The parent letter was available in both English and Spanish or English and Chinese. With a low-risk anonymous survey being implemented schoolwide, all of the principals, the principal investigators, and the Institutional Review Boards felt that passive parental consent was sufficient and in line with general Board of Education practice. Attached to the letter was a form for parents to return to the researchers if they did not want their child to participate in the study. An addressed and stamped envelope was included for parents to send this letter back to the researchers. If the parents did want their child to participate no action was required. This is similar to Department of Education procedures for HIV education, condom distribution, and military recruitment.

Students were informed of the survey one week in advance of its administration by their health and physical education teachers and were handed a student information brochure. On the day of the study, students were invited to participate and were asked for verbal assent, to preserve anonymity of participation. Students whose parents opted them out of the study and students who decided not to participate were given alternate activities by the school and did not take part in the survey. The research associate and a teacher, who were trained to review assent information and answer questions, were present in the classroom during the study.

Two high schools used a paper and pencil version of the survey and two used the audio-computer-

assisted (ACASI) version. The school staff arranged for groups of students taking the survey to be in a classroom or gymnasium, outside of instructional time. The research associate distributed the paper copy with pencils or set up the survey on laptops or desktop computers. The students were placed so that they could not see each other's responses. Students were offered a \$10 gift card to Barnes & Noble as a participation incentive.

Due to the sensitive nature of the survey questions, the study partners felt it was imperative to provide students with referral information for counseling services. The Alliance created the NYC Teen Health Map to provide youth-friendly sexual and dating violence referral information in a discrete way. Maps were given to every youth in the four participating schools, regardless of study participation. Trained rape crisis advocates were also available during the entire data collection period in case a student wanted to talk to someone or receive further information. Several members of the research staff were also trained in crisis counseling.

Overall, 1,454 students participated in the study and answered at least one question on the survey. Of these, 64 surveys were incomplete and were eliminated due to the extensive missing data. An additional 20 individuals did not provide responses to any questions on the Conflict in Adolescent Dating Relationships Inventory (CADRI) or the Dating Violence Inventory (DVI) measurements. Finally, 33 students did not answer sufficient questions on the DVI to score at least one scale and 25 students did not answer sufficient questions on the CADRI to score at least one subscale. Thus, the total sample size was composed of 1,312 students who had adequate data to be used in the present analyses. A comparison between those who had sufficient data with those who did not revealed that males were more likely to have large amounts of missing data on surveys (57% vs. 43%, $p < .005$), younger students were more likely than older students to have missing data (15.6 years vs. 15.9 years, $p < .05$), and those who reported using the paper and pencil version opposed to the ACASI (68% vs. 32%, $p < .05$).

The response rate for the study was 70%. In all, 46 parents opted their child out of the study and 52

Table 15: Sample Distribution*

Total Sample: 1,312

(The data from one survey from either gender is missing.)

	% of sample (n)
Gender	
Female	56 (737)
Male	44 (574)
Age	
13 to 14	18 (239)
15 to 16	48 (628)
17 and older	34 (439)
Grade	
9th	28 (369)
10th	25 (321)
11th	24 (317)
12th	23 (298)
Race/Ethnicity	
Latino	73 (962)
Black	19 (245)
White	2 (29)
Asian	3 (43)
Other	2 (31)
Foreign-Born	23 (304)
Speak English at Home	66 (856)
Household Composition	
One-Adult Family	51 (663)
Two-Adult Family	45 (579)
No Adults Living in Family	4 (52)
Sexual Orientation	
Heterosexual	91 (922)
Homosexual	2 (20)
Bisexual	5 (55)
"Not sure"	2 (17)
Survey Method	
Paper/pencil Survey	59 (771)
ACASI	41 (541)
Had Sex in the Last Year	49 (641)

youth opted not to take the survey. More females than males were surveyed (56% vs. 44%). Latinos are overrepresented in this study, representing 73% of the sample. This is due in part to the majority Latino population of three of the participating schools. Future research should be conducted with a representative sample, with schools in all five boroughs and with a diverse student population. The sample distribution is displayed in Table 15.

Survey Design

The same survey questionnaire that was used to survey 638 young women in the CCYVP and Planned Parenthood NYC study was used for this study with a few small differences. Screening questions were removed, and a series of questions on sexual violence, help-seeking and help-giving behaviors, and some open-ended questions were added. The survey was piloted with youth (n=25) in order to determine clarity of the language used and to estimate the time needed to complete the survey. Teenagers' comments were collected and taken into consideration when finalizing the questionnaire.

The Alliance's Research Advisory Committee and Columbia's study advisory committee reviewed the survey instrument, in addition to all the principals involved in the study. Feedback was incorporated and is reflected in the current survey design.

The survey includes questions in the following areas:

1. Demographics,
2. Nature of their dating relationships,
3. Physical/verbal/sexual abuse within past and recent dating relationships,
4. Experiences of nonpartner sexual violence,
5. Exposure to other forms of violence,
6. Help-seeking and help-giving behaviors,
7. Opinions about dating violence and suggestions for future interventions, and
8. Nonintrusive general health questions.

* Missing data excluded.

Numbers rounded to the nearest whole number.

The demographics section included questions on age, sex, grade, race/ethnicity, and working status. This section also included questions on the language most often spoken at home, whether the respondent was born in the United States, and with whom the respondent currently lives. Finally, this section asked if the respondent had started dating or had any romantic and/or sexual relationships. This was used as a screener question for the following sections. This section also included several NYC Youth Risk Behavior Survey (YRBS) items such as respondent marriage status, if they've ever been pregnant or gotten someone pregnant, and how many babies they have or had fathered.

In the second section of the survey, students were asked about the nature of their dating relationships. Respondents were asked about their sexual orientation and if they had sex in the last year. This section also included two YRBS questions: one on forced sex and one on dating violence. The researchers included a follow-up question to both of these about formal help-seeking ("If yes, during the last 12 months, did a boyfriend or girlfriend hurt you so bad that you had to be treated by a doctor or nurse?" and "If yes, did you see a doctor at that time because of this unwanted sexual experience?"). This section also asks questions about their current or most recent partner (regarding sex, if they are still dating, how long they dated, how old the person is, and how important the relationship is/was to the respondent). This section leads directly into section three, which covers behaviors that have occurred during a conflict or argument with their partner within the last year.

In order to assess relationship violence in section three, the Conflict in Adolescent Dating Relationships Inventory, which measures victimization and perpetration of physical, sexual, and emotional/verbal violence by a sexual or romantic partner in the last year was chosen (Wolfe *et al.*, 2001). In addition, to measure lifetime occurrence of violence, the Dating Violence Inventory was employed (Symons *et al.*, 1994). Finally, to assess controlling behaviors and practices by a romantic partner, several items from the World Health Organization (WHO) Multicountry Study were added, including: "My partner is suspicious that I am

unfaithful, tries to keep me from seeing my friends, and gets angry if I speak to another man" (Garcia-Moreno *et al.*, 2005).

Several questions were included to explore non-partner sexual violence. Specifically, the researchers were interested in learning in what context youth were experiencing sexual violence. These questions asked if youth had been forced to have sex or had been sexually abused by a parent or guardian, a family member other than a parent, an older acquaintance, a nonpartner peer, or a stranger. The survey also included questions on the frequency of the abuse.

Exposure to other forms of violence was measured using YRBS questions. Questions included whether the respondent felt unsafe at school or on their way to or from school, if they had carried a weapon in the last 30 days, if they have been threatened or injured with a weapon in the past year, if they had been in a physical fight during the last year, and if they had been a member of a gang in the last year. The YRBS questions were included for purposes of comparison with NYC and national data.

Help-seeking and help-giving behaviors among youth were explored with several detailed questions, including whether the respondent had ever told anyone about experiencing sexual or dating violence, who they told first, how long before they told someone and how many people they told overall. Another series of questions asked if the respondent had received any information or education about dating and sexual violence and from what sources. Finally, several questions asked youth if they have a friend in a violent relationship. If they responded yes, they were asked if they had given their friend any advice and the nature of the advice given.

Open-ended questions were added to gather opinions about dating violence and ideas for prevention programming. Specifically, youth were asked how dating or sexual violence has affected them, what they thought would reduce sexual or dating violence in the lives of teens, and what the schools should do to reduce or prevent sexual or dating violence. The respondents were also given a space to fill out other information that they wanted to share with the researchers on the topic.

Since students who had experienced intimate partner violence needed to answer more follow-up questions than those who had not, we included a series of noninvasive general health questions at the end of the survey to guarantee that all students complete the survey at the same time and therefore protect the confidentiality of those who answer yes to violence questions. Without these questions, the health and relationships survey would have required more time to complete for a participant who has experienced violence in a relationship than for a participant who has not experienced any. These differences in survey completion time could have potentially allowed students to identify those students who reported relationship violence, thus threatening the confidentiality of their responses. The health questions were drawn from the Child Health Illness Profile—Adolescent Edition (CHIP—AE) (Riley *et al.*, 1998). The research associates introduced the survey in a manner similar to that used in college preparatory exams: “Few of you will have time to complete the survey in the time allotted. We expect this. Continue to answer the questions up until I tell you to stop or until you have completed the survey.”

Translations

The piloted survey was translated into Spanish. The experiences and translation of the CADRI as reported by Hokoda and colleagues (2006) were especially helpful in translating that instrument. To ensure the robustness of the translation, the survey was back-translated by a different translator from Spanish to English. Questions that back-translated into confusing wording or different interpretations of the questions were examined by the research team in conjunction with the translators. A final translation was produced and reviewed by Spanish-speaking research staff. Similarly, the parent letters were translated into Spanish and Chinese and were reviewed but not back-translated.

ACASI Programming

Once the survey was finalized in both English and Spanish versions, the surveys were developed into an ACASI program. Little research exists about the effect the gender of the speaker has on survey

completion. For this reason, the study randomized with both male and female voices in both English and Spanish for study respondents completing the ACASI survey. The gender of the voice on the ACASI program made no significant difference in responses or completion rates.

The ACASI program was piloted with both Mac and PC computers, laptops and desktop computers, computers that had different processing powers, and on the specific networks in the two schools. The ACASI program was installed on the school network using an administrator password. The research associates logged into each computer to set up the survey by using their initials and the date. The survey data was stored in a nonreadable file on each computer and was taken off each individual computer at the end of each survey session. No study information was stored on the school computers. Data files were then downloaded as a group into Microsoft’s Excel program and transferred at the end of the data-collection period to the statistical analysis software. During the data-transfer process, several data file errors developed on specific surveys. These data files were sent to the ACASI programmer, who was able to locate the source of the error, correct it, and resend it to the researchers to upload in the database. A total of 24 surveys were corrected in this manner.

Data Entry

A total of 541 surveys (41%) were completed using the ACASI program and the remaining 771 (59%) were completed using the paper and pencil method. The paper surveys were manually entered into the ACASI program. The Alliance held a one-day training in January 2007 to train three data-entry volunteers. The research team conducted data checking on every seventh survey entered into the database and regularly met with the data-entry team to answer questions and provide guidance. After all data were imported into an electronic database for analyses, extensive data cleaning was conducted, including identification of missing information, out-of-range checks, and cross-checking responses between similar questions.

Data Analysis

Frequencies were calculated and reviewed for all variables in the study. Several variables were collapsed into dichotomous variables for the purposes of multivariate analyses. CADRI variables were divided into scales. Bivariate analysis was conducted for variables that were suspect or had been shown to vary by age, ethnicity, or violence history using chi-square tests stratified by gender. Variables significant at the $p < .10$ level were considered for entry into a logistic regression, designed to identify predictors of sexual and physical violence perpetration and victimization. Multivariable odds ratios with associated 95% confidence intervals were computed and reported. All statistics are rounded and reported to the nearest whole number. Percentages that ended in .5 were rounded up if the preceding number was odd and rounded down if the preceding number was even.

The study partners shared a master database and continually sent each other updated syntax for the data analysis. Qualitative data, while not presented in this report, were analyzed using emergent categories to code the data using cross-case analysis. The quantitative analyses as presented in this report were also reviewed by the Alliance's Research Advisory Committee and the CCYVP study advisory group.

Both study partners agreed on the importance of giving the data back to the participants in the study. Individual school-specific reports were created and presented to school personnel, parents, and students for feedback. The study partners continue to work with the specific schools on implementing intervention and prevention programming based on their specific needs.

Limitations

Due to the difficulties in sampling schools for a dating violence study, a nonrandom sampling methodology was utilized. Because some schools had no chance of being sampled, the extent to which this sample represents youth in public schools in NYC cannot be known. Furthermore, it is not known if schools that chose to participate were different from schools that did not choose to participate (they

have higher or lower rates of violence, more committed staff, etc.). However, the study was able to compare the data to NYC YRBS data on several variables and found that estimates were very similar to NYC reported rates of violence. This study focuses only on public high schools. Future research should be conducted with private schools. Despite these limitations the study provides tremendous insight into the violent experiences of youth in NYC.

Validity

Internal Validity

A study is valid if its questions actually measure what they claim to, and if there are no logical errors in drawing conclusions from the data. "Internal validity" is a term that refers to whether variables other than those being studied may have in some way affected the outcome or variable under study. Several threats to internal validity were examined and addressed.

One threat to internal validity is known as the "Hawthorne Effect," which postulates that the expectation or actions of the investigator may contaminate the outcomes of the study. Does administering a survey within the school setting have an impact on the respondents' responses to dating violence questions? This threat has been minimized by not having teachers administer the survey and by assuring participants about their anonymity.

Another threat to internal validity is selection bias. This is a concern—the schools that decided to participate in the study may differ significantly from schools that decided not to participate. This also applies to the second level of sampling: Are students whose parents did not want them to participate significantly different than the students who did participate?

Closely tied to selection bias is maturation bias—the possibility that older youth were more likely to have experienced sexual or dating violence than younger youth. This potential bias was addressed by controlling for age in multivariate models.

Another form of selection bias may occur due to the higher literacy level required to complete the paper and pencil survey compared to the ACASI system,

in which respondents hear the survey being read to them while they see the survey on a computer screen. To address this, efforts were made to lower the literacy level of the survey overall.

History of violence prevention programming is also recognized as a threat to internal validity. Did the schools that participated have a longer history of sexual and dating violence programming in their schools? Would this lead to those youth being more likely to answer in the affirmative to sexual and dating violence behaviors due to these awareness-raising programs? To the study's knowledge, none of the schools that participated had any in-depth, systematic programming on violence prevention.

External Validity

In addition to internal validity, studies should also be concerned with "external validity," which focuses on the possible biases that may occur in generalizing conclusions from a sample to other populations, other settings, and/or other time periods. The population for this study was NYC public high school students. The largest weakness in this study occurred with external validity, due to the nonrandom selection of schools. Due to these limitations, results from this study are not generalizable to the entire public high school student population of New York City.

Despite these threats to external validity, efforts were made to limit the effect of these biases. The training of data collectors helped minimize external validity by ensuring all youth were approached in a similar manner to participate in the study.

Due to the large numbers of Latino youth at three of the four participating high schools, Latino youth are overrepresented in this study. As such, study results may not be generalizable to youth from other racial/ethnic backgrounds.

Construct Validity

"Construct validity" seeks agreement between a theoretical concept (such as dating violence) and a specific measuring device or procedure. Construct validity examines the biases involved in generalizing from the measures or questions to the concept behind them. When the study asks about dating violence is that what is really being measured? Threats to construct validity have been addressed by using validated measurements and by ensuring that the survey instrument was piloted with youth.

Appendix B: Survey Instrument

HEALTHY RELATIONSHIPS SURVEY: DATING AND CONFLICT

* This survey is copyrighted. Please do not replicate the survey in whole or part without prior permission from the New York City Alliance Against Sexual Assault or the Columbia University Center for Youth Violence Prevention (contact research@nycagainstrape.org or vir2002@columbia.edu)

SECTION 1

In order to create a code for your answers, WITHOUT asking for your name or any other information that would identify you, we are going to start by asking a few general questions about you.

- B1. How old are you?
- ☐ 13 years or younger ☐ 18 years old
- ☐ 14 years old ☐ 19 years old
- ☐ 15 years old ☐ 20 years old
- ☐ 16 years old ☐ 21 years or older
- ☐ 17 years old
- B2. Are you?
- ☐ Female
- ☐ Male
- B3. Are you currently:
- ☐ Working part-time
- ☐ Working full-time
- ☐ Not working
- B4. What grade are you in?
- ☐ 9th ☐ 11th
- ☐ 10th ☐ 12th
- ☐ Other grade
- B5. Are you of Latino descent or background?
- ☐ Yes
- ☐ No
- B5a. If yes, which Latino group(s) do you most identify with (or belong to)? *(Choose ALL that apply)*
- I am: ☐ Dominican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Mexican
- ☐ Another Latino group
- B6. Which racial group(s) do you identify with (or belong to)? *(Choose ALL that apply)*
- I am: ☐ Black (including African American, African, and Caribbean)
- ☐ White
- ☐ Asian
- ☐ Another racial group
- B7. Were you born in the U.S.?
- ☐ Yes ☐ No
- B8. Is English the language you speak at home most of the time?
- ☐ Yes *(If yes, GO TO Question B9)*
- ☐ No
- B8a. If no, what language do you speak at home most of the time?
- ☐ Spanish ☐ French ☐ Hindi
- ☐ Chinese ☐ Creole ☐ Korean
- ☐ Other language

- B9. Who do you **currently** live with? (*CHOOSE ALL THAT APPLY.*)
- ☐ By myself ONLY ☐ Boyfriend or girlfriend
☐ My child/children ☐ Mom/stepmom
☐ Dad/stepdad ☐ Other adult relative
☐ Mother's boyfriend ☐ Other adult (not a relative)
☐ Roommate(s)/Friend(s)
☐ Dad's girlfriend ☐ Brothers/sisters

Some people start dating or having sexual relationships when they are quite young and others start much later.

- B10. Have you started dating, or had ANY romantic and/or sexual relationships?
- ☐ No (*IF NO, PLEASE GO TO PAGE 11, "Section 5"*)
☐ Yes

- B11. Have you **ever** been married?

☐ Yes ☐ No

- B11a. If yes, are you **now**:

☐ Still married ☐ Divorced
☐ Separated ☐ Widowed

- B12. **If you are female**, have you ever been pregnant (including any abortions or miscarriages)?

If you are male, have you ever gotten someone pregnant?

☐ Yes ☐ No (*IF NO, PLEASE GO TO Section 2*)

- a) If yes, how many times have you been pregnant? (*for females only*)

If yes, how many times have you gotten someone pregnant? (*for males only*)

☐ 1 ☐ 3
☐ 2 ☐ 4 or more

- b) Have you had any babies? (*for females*) / Are you the father of any babies? (*for males*)

☐ No ☐ Yes, 2 babies
☐ Yes, 4 or more babies
☐ Yes, 1 baby ☐ Yes, 3 babies

SECTION 2

In this section, we're going to ask you more in-depth questions about your dating and sex life, both now and in the past.

When we ask about your "partners," we mean anyone who you have a romantic or sexual interest in. So a "partner" could be your boyfriend or girlfriend, your man or woman, your sex partner, or someone who you have just gone out with. You could have a serious romantic interest in this person, a sexual interest, or maybe both. You could be committed to this person, or you two could have an "open" relationship, where you date other people.

- R1. First, how do you think of yourself privately?

I am: ☐ straight
☐ gay/lesbian
☐ bisexual
☐ I'm not sure

- R2. I have dated or gone out with males:

☐ in the past ☐ currently
☐ in the past and currently
☐ not at all

- R3. I have dated or gone out with females:

☐ in the past ☐ currently
☐ in the past and currently
☐ not at all

- R4. I have dated or gone out with more than one person at a time:

☐ in the past ☐ currently
☐ in the past and currently
☐ not at all

- R5. Did you have sex in the last year?

☐ No
☐ Yes

- R6. During the past 12 months, did a boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

☐ No (*If NO, GO TO Question R7*)
☐ Yes

R6a. If yes, during the past 12 months, did a boyfriend/ girlfriend hurt you so bad that you had to be treated by a doctor or nurse?

- ☐ 0 times
- ☐ 1 time
- ☐ 2 or 3 times
- ☐ 4 or more times

R7. Have you ever been physically forced to have sexual intercourse when you did not want to?

- ☐ No *(If NO, GO TO Question R8)*
- ☐ Yes

R7a. If yes, did you see a doctor at that time because of this unwanted sexual experience?

- ☐ No
- ☐ Yes

Now we are going to ask you a lot of questions about your **current or most recent** partner in more detail on pages 5-9. Again, when we ask about your “partners,” we mean anyone who you have a romantic or sexual interest in. A “partner” could be your boyfriend or girlfriend, your man or woman, your sex partner, or someone who you have just gone out with. You could have a serious romantic interest in this person, a sexual interest, or maybe both. You could be committed to this person, or you two could have an “open” relationship, where you date other people.

R8. Do you **currently** have a partner OR have you had a partner **within the last year**?

- ☐ No *(IF NO, PLEASE GO TO PAGE 10, “Section 4”)*
- ☐ Yes

R9. Is this partner:

- ☐ male
- ☐ female

R10. Please choose which statement describes your relationship with this person:

- ☐ I am thinking of somebody who is my partner **right now**.
- ☐ I am thinking of someone I dated **within the past 3 months**.
- ☐ I am thinking of a partner I dated more than 3 months ago but **within the past year**.

R11. How long have you dated or did you date this person?

- ☐ less than a month
- ☐ more than a month, less than 3 months
- ☐ more than 3 months, less than 6 months
- ☐ more than 6 months, less than 1 year
- ☐ 1 year
- ☐ 1 to 2 years
- ☐ more than 2 years

R12. How old is this person now? _____

R13. How important is/was this relationship to you? *(Choose one of the responses below.)*

- ☐ Not at all important
- ☐ Somewhat important
- ☐ Important
- ☐ Very important

R14. Please check which one of the following six answers BEST describes your relationship to this person:

- ☐ We are/were dating other people as well.
- ☐ I am/was dating this person without any definite commitment.
- ☐ I am/was dating this person exclusively.
- ☐ We are/were living together, but not engaged.
- ☐ We are/were engaged.
- ☐ We are/were married.

R15. Please check which one of the following BEST describes your **sexual** relationship with this person:

- ☐ We have not had sex with one another.
- ☐ We only have sex with each other.
- ☐ We allow each other to have sex with other people.
- ☐ I am having sex with other people without telling my partner.
- ☐ I suspect my partner is having sex with others without telling me.

SECTION 3

All dating couples have disagreements. The following questions ask you about things that may have happened to you with your partner while you were having an argument. Put a check in the box that is your best estimate of how often these things have happened with your current or ex-partner **within the past year** [this should be the same partner you just described]. Please remember that all answers are completely anonymous. As a guide, use the following scale:

Never: This has never happened in my relationship.
Seldom: This has happened only 1-2 times in my relationship.
Sometimes: This has happened about 3-5 times in my relationship.
Often: This has happened 6 times or more in my relationship.

During a conflict or argument with my partner in the past year: Put an "X" in appropriate box

	Never	Seldom	Sometimes	Often
RS1. I threatened to hit him/her or throw something at him/her.				
S/he threatened to hit me or throw something at me.				
RS2. I touched him/her sexually when s/he didn't want me to.				
S/he touched me sexually when I didn't want him/her to.				
RS3. I threatened to end the relationship.				
S/he threatened to end the relationship.				
RS4. I did something to make him/her feel jealous.				
S/he did something to make me feel jealous.				
RS5. I destroyed or threatened to destroy something s/he valued.				
S/he destroyed or threatened to destroy something I valued.				

During a conflict or argument with my partner in the past year: *Put an "X" in appropriate box*

	Never	Seldom	Sometimes	Often
RS6. I told him/her that I was partly to blame.				
S/he told me that s/he was partly to blame.				
RS7. I brought up something bad that s/he had done in the past.				
S/he brought up something bad that I had done in the past.				
RS8. I threw something at him/her.				
S/he threw something at me.				
RS9. I said things just to make him/her angry.				
S/he said things just to make me angry.				
RS10. I gave reasons why I thought s/he was wrong.				
S/he gave reasons why s/he thought I was wrong.				

During a conflict or argument with my partner in the past year: *Put an "X" in appropriate box*

	Never	Seldom	Sometimes	Often
RS11. I agreed that s/he was partly right.				
S/he agreed that I was partly right.				
RS12. I spoke to him/her in a hostile or mean tone of voice.				
S/he spoke to me in a hostile or mean tone of voice.				
RS13. I forced him/her to have sex when s/he didn't want to.				
S/he forced me to have sex when I didn't want to.				
RS14. I offered a solution that I thought would make us both happy.				
S/he offered a solution that s/he thought would make us both happy.				
RS15. I threatened him/her in an attempt to have sex with him/her.				
S/he threatened me in an attempt to have sex with me.				

During a conflict or argument with my partner in the past year: *Put an "X" in appropriate box*

	Never	Seldom	Sometimes	Often
RS16. I put off talking until we calmed down.				
S/he put off talking until we calmed down.				
RS17. I insulted him/her with put-downs.				
S/he insulted me with put-downs.				
RS18. I discussed the issue calmly.				
S/he discussed the issue calmly.				
RS19. I kissed him/her when s/he didn't want me to.				
S/he kissed me when I didn't want him/her to.				
RS20. I threatened to hurt him/her.				
S/he threatened to hurt me.				

During a conflict or argument with my partner in the past year: *Put an "X" in appropriate box*

	Never	Seldom	Sometimes	Often
RS21. I ridiculed or made fun of him/her in front of others.				
S/he ridiculed or made fun of me in front of others.				
RS22. I told him/her how upset I was.				
S/he told me how upset s/he was.				
RS23. I kept track of who s/he was with and where s/he was.				
S/he kept track of who I was with and where I was.				
RS24. I blamed him/her for the problem.				
S/he blamed me for the problem.				
RS25. I kicked, hit or punched him/her.				
S/he kicked, hit, or punched me.				

During a conflict or argument with my partner in the past year: *Put an "X" in appropriate box*

	Never	Seldom	Sometimes	Often
RS26. I left the room to cool down.				
S/he left the room to cool down.				
RS27. I pushed, shoved, or shook him/her.				
S/he pushed, shoved, or shook me.				
RS28. I accused him/her of flirting with someone else.				
S/he accused me of flirting with someone else.				
RS29. I deliberately tried to frighten him/her.				
S/he deliberately tried to frighten me.				
RS30. I slapped him/her or pulled his/her hair.				
S/he slapped me or pulled my hair.				

Thinking about the same partner, *how often* would you say:

	Never	Seldom	Sometimes	Often
RS31. S/he tries to keep me from seeing my friends.				
I try to keep him/her from seeing his/her friends.				
RS32. S/he tries to restrict contact with my family.				
I try to restrict contact with his/her family.				
RS33. S/he insists on knowing where I am at all times.				
I insist on knowing where he/she is at all times.				
RS34. S/he ignores me and treats me indifferently.				
I ignore him/her and treat him/her indifferently.				
RS35. S/he gets angry if I speak with another man/woman.				
I get angry if he/she speaks to another man/woman.				
RS36. S/he is often suspicious that I am unfaithful.				
I am suspicious that he/she is unfaithful.				
RS37. S/he checks my cell phone to see who I call. I don't have a cell phone <input type="checkbox"/>				
I check his/her cell phone to see who he/she calls. S/he does not have a cell phone <input type="checkbox"/>				
RS38. S/he checks my e-mail. I don't have email <input type="checkbox"/>				
I check his/her email. S/he does not have email <input type="checkbox"/>				

RS39. My partner and I are/were having sex.

- ☐ No (*IF NO, go to question RS40a.*)
☐ Yes

RS39a. I have refused to have sex with a condom even when my partner asked me to.

- ☐ Never
☐ Seldom
☐ Sometimes
☐ Often
☐ My partner has never asked me to use a condom

RS39b. My partner refused to have sex with a condom even when I asked him/her to.

- ☐ Never
☐ Seldom
☐ Sometimes
☐ Often
☐ I have never asked my partner to use a condom

RS40a. Some people are afraid that their partner will hurt them if they argue or do something their partner doesn't like. How much would you say you are afraid of him/her?

- ☐ not at all
☐ a little
☐ quite a bit
☐ very afraid

RS40b. Some people are afraid that their partner will hurt them if they argue or do something their partner doesn't like. How much would you say your partner is afraid of you?

- ☐ not at all
☐ a little
☐ quite a bit
☐ very afraid

SECTION 4

Now we would like you to think back over **ALL** the romantic or sexual relationships that you have **EVER** had in your life, and answer the following questions.

We are going to ask whether you have **EVER** experienced violence in your relationships, current and past. Again, when we ask about your relationship or your "partners," we mean anyone who you have or had a romantic or sexual interest in. So a "partner" could be your boyfriend or girlfriend, the person you call your "man" or "woman," your sex partner, or someone who you have just gone out with. You could have a long-term interest in this person, a sexual interest, or maybe both. You could be committed to this person, or you two could have an "open" or "casual" relationship, where you date other people.

How often in your life has ANY (current or previous) partner EVER: Put an "X" in appropriate box

	Never	Once	Twice	3 times	4 or more times
D1. Pushed or shoved you?					
D2. Held you to keep you from leaving?					
D3. Slapped or hit you?					
D4. Punched you?					
D5. Choked you?					
D6. Threw objects at you?					
D7. Subjected you to reckless driving?					

continued on next page

D8. Threatened to hurt you?					
D9. Threatened to hurt you with a weapon?					
D10. Hurt you with an object or a weapon?					
D11. Tried to force you into sexual activity?					
D12. Raped you?					
D13. Ignored your feelings?					
D14. Criticized you?					
D15. Ridiculed your ideas?					
D16. Shouted at you?					
D17. Called you names?					
D18. Insulted your family?					
D19. Insulted your friends?					
D20. Humiliated you in private?					
D21. Humiliated you in public?					
D22. Made decisions for you?					
D23. Acted extremely jealous?					

SECTION 5

Many people experience sexual violence outside of dating relationships, both by people they know and by strangers. This section asks what types of sexual violence you may have experienced in your life. When we ask about “sexual abuse,” we mean any sexual fondling, touching, oral sex or intercourse (penetration of the vagina or anus with a penis, fingers or object).

How often in your life has: *Put an “X” in appropriate box*

	Never	Once	Twice	3 times	4 or more times
F1. Your parent sexually abused you or forced you to have sex?					
F2. A family member other than a parent sexually abused you or forced you to have sex?					
F3. An older acquaintance (such as a family friend, teacher, minister, neighbor, etc.) sexually abused you or forced you to have sex?					
F4. Someone else your age who you knew but was not your partner sexually abused you or forced you to have sex?					
F5. A stranger sexually abused you or forced you to have sex?					

SECTION 6

- N1. During the past 30 days, on how many days did you **not** go to school because you felt you would be unsafe at school or on your way to or from school?
- ☐ 0 days
 - ☐ 1 day
 - ☐ 2 or 3 days
 - ☐ 4 or 5 days
 - ☐ 6 or more days
- N2. During the past 30 days, on how many days did you carry **a weapon** such as a gun, knife, or club?
- ☐ 0 days
 - ☐ 1 day
 - ☐ 2 or 3 days
 - ☐ 4 or 5 days
 - ☐ 6 or more days
- N3. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club?
- ☐ 0 times
 - ☐ 1 time
 - ☐ 2 or 3 times
 - ☐ 4 or 5 times
 - ☐ 6 or 7 times
 - ☐ 8 or 9 times
 - ☐ 10 or 11 times
 - ☐ 12 or more times
- N4. During the past 12 months, how many times were you in a physical fight?
- ☐ 0 times
 - ☐ 1 time
 - ☐ 2 or 3 times
 - ☐ 4 or 5 times
 - ☐ 6 or 7 times
 - ☐ 8 or 9 times
 - ☐ 10 or 11 times
 - ☐ 12 or more times
- N5. At any time during the past 12 months, have you been a member of a gang?
- ☐ Yes
 - ☐ No

SECTION 7

- M1. Did you ever tell anyone about EXPERIENCING ANY physical and sexual violence from a partner?
- ☐ Never happened to me (GO TO QUESTION M2)
 - ☐ Never told anyone (GO TO QUESTION M2)
 - ☐ Yes, I have told someone about the physical violence from a partner
 - ☐ Yes, I have told someone about the sexual violence from a partner
 - ☐ Yes, I have told someone about both the physical and sexual violence from a partner
- If yes,
- a) How much time passed before you told someone about the physical and/or sexual violence from a partner?
- | | |
|--|--|
| <input type="checkbox"/> I never told anyone | <input type="checkbox"/> one week |
| <input type="checkbox"/> 6 months | <input type="checkbox"/> less than one day |
| <input type="checkbox"/> 2–3 weeks | <input type="checkbox"/> 7–12 months |
| <input type="checkbox"/> 1–2 days | <input type="checkbox"/> 1 month |
| <input type="checkbox"/> 13–24 months | <input type="checkbox"/> 3–6 days |
| <input type="checkbox"/> 2–5 months | <input type="checkbox"/> more than 2 years |
- b) How many different people have you told about this experience(s)? _____

c) Who did you tell first? (CHOOSE only ONE)

- ☐ parent ☐ doctor or health professional
☐ friend ☐ minister, priest, or rabbi
☐ therapist or counselor ☐ other adult _____

d) Who else did you tell? (CHOOSE all that apply)

- ☐ parent ☐ doctor or health professional
☐ friend ☐ minister, priest, or rabbi
☐ therapist or counselor ☐ other adult _____

e) Did you seek help from a health professional, teacher, or guidance counselor because of this experience(s)?

- ☐ No
☐ Yes, I sought help from _____

M2. Have you received any **information or education** about dating violence?

- ☐ No (go to next question) ☐ Yes

If yes, was this information or education about dating violence from (choose all that apply):

- ☐ school
☐ TV
☐ a friend
☐ a doctor or nurse
☐ magazine
☐ Advertisement
☐ Family member
☐ Brother or sister
☐ Other _____

M3. Have you received any information or education about sexual violence (sexual assault, rape, sexual abuse)?

- ☐ No (go to Question M4) ☐ Yes

If yes, was this information or education about sexual violence from (choose all that apply):

- ☐ school
☐ TV
☐ a friend
☐ a doctor or nurse
☐ magazine
☐ Advertisement
☐ Family member
☐ Brother or sister
☐ Other _____

M4. Do you have a friend in a violent relationship?

- ☐ No (go to next question) ☐ Yes

If yes:

Have you talked to this friend about the violence?

- ☐ Yes ☐ No

Have you called a hotline to figure out how to help your friend?

- ☐ Yes ☐ No

Have you given this friend advice?

- ☐ Yes ☐ No

Have you told him/her to call a hotline?

- ☐ Yes ☐ No

Have you told him/her to talk to an adult?

- ☐ Yes ☐ No

Have you gone with your friend to get some help like at a clinic?

- ☐ Yes ☐ No

Have you told him/her to leave this partner?

- ☐ Yes ☐ No

Have you talked to the partner directly about his/her violence?

- ☐ Yes ☐ No

Have you talked to an adult about your friend's problem?

- ☐ Yes ☐ No

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YOUR OWN WORDS IN THE SPACE PROVIDED

M5. How has dating violence or sexual violence affected you?

M6. What do you think would reduce sexual or dating violence in the lives of teens?

M7. What should the schools do to reduce or prevent sexual or dating violence?

M8. Is there anything else you want to tell us about dating and violence?

Section 8

We have asked you many questions about your dating and personal relationships. Now we would like to ask you some general questions about your health.

For the next 10 statements, check the box to show if you **completely agree, mostly agree, agree a little, or do not agree** with the statement.

	Completely agree	Mostly agree	Agree a little	Do not agree
Q1. I am full of energy				
Q2. When I get sick, I usually recover quickly				
Q3. I am well coordinated				
Q4. I have a lot of good qualities				
Q5. I am very physically fit				
Q6. I have much to be proud about				
Q7. I like being the way I am				
Q8. I am satisfied with how I live my life				
Q9. My muscle strength is really good				
Q10. I feel socially accepted				

Q11. How is your health in general?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

These questions are about how you have been feeling over the **PAST 4 WEEKS**. Please check the box to indicate your answer to each question.

In the PAST 4 WEEKS, on how many days...

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
C1. Did you feel really sick?					
C2. Did you wake up feeling tired?					
C3. Did you tire easily or feel like you had no energy?					
C4. Did you have watery or itchy eyes?					
C5. Did you have a cough?					
C6. Did you have fever or chills?					
C7. Were you dizzy?					
C8. Did you have wheezing or trouble breathing (when you weren't exercising)?					
C9. Did you have chest pain?					
C10. Did you have a headache?					
C11. Did you have aches, pains or soreness in your muscles or joints?					
C12. Did you have a stomach ache?					
C13. Did you have pain that really bothered you?					
C14. Did you vomit or feel like vomiting?					
C15. Did you have trouble eating or have a poor appetite?					
C16. Did you have trouble falling asleep or staying asleep?					
C17. Did you have trouble relaxing?					
C18. Were you nervous or uptight?					
C19. Were you moody?					
C20. Were you irritable or grouchy?					
C21. Did you wake up feeling refreshed?					
C22. Did you feel really healthy?					
C23. Did you feel like you were doing everything just right?					

In the PAST 4 WEEKS, on how many days did a *health or emotional problem* cause you to...

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
C24. Stay in bed more than half a day, but not miss school?					
C25. Cut down on other things you usually do, but not miss school or stay in bed?					
C26. Have trouble walking?					
C27. Have trouble running?					
C28. Have trouble bending, lifting, stooping or reaching?					
C29. Have trouble using your hands or fingers, like writing with a pencil, tying your shoelaces, or buttoning clothing?					

C30. In the PAST 4 WEEKS, have you lost weight without trying?

- ☐ No
- ☐ Yes, 1 to 4 pounds
- ☐ Yes, 5 to 9 pounds
- ☐ Yes, 10 to 14 pounds
- ☐ Yes, more than 15 pounds

C31. In the PAST 4 WEEKS, on how many days did you exercise or play sports hard enough to make you breathe hard, make your heart beat fast, or make you sweat for 20 minutes or more?

- ☐ No days
- ☐ 1 to 9 days ☐ 14 to 20 days
- ☐ 10 to 13 days ☐ 21 or more days

C32. In the PAST 4 WEEKS, how many sit-ups did you do the last time you did them?

- ☐ No sit-ups
- ☐ 1-10 sit-ups
- ☐ 11-20 sit-ups
- ☐ 21-50 sit-ups
- ☐ 51 or more sit-ups

C33. In the PAST 4 WEEKS, how far did you walk at any one time without resting and without getting tired?

- ☐ I didn't walk at all
- ☐ Less than a quarter of a mile (less than 2 blocks)
- ☐ A quarter mile to one half mile (3 to 6 blocks)
- ☐ One half mile to one mile (6 to 12 blocks)
- ☐ More than one mile (more than 12 blocks)

C34. In the PAST 4 WEEKS, what is the longest time you ran without stopping?

- ☐ I didn't run
- ☐ 1 to 10 minutes
- ☐ 11 to 19 minutes
- ☐ 20 to 29 minutes
- ☐ 30 minutes or more

C35. In the PAST 12 MONTHS, how often did you play on a team that has a coach, other than in gym class?

- ☐ Never
- ☐ Once or twice
- ☐ Several times

C36. In the PAST 4 WEEKS, about how many hours did you usually watch TV or videos on an average school day?

- ☐ None
- ☐ Less than 1 hour
- ☐ 1 to 2 hours
- ☐ 3 to 4 hours
- ☐ 4 or more hours

When was the last time you did this?

	Never	More than a year ago	In the past year	In the past month	In the past week
C37. Rode a bicycle?					
C38. Wore a helmet when riding a bicycle?					
C39. Rode a motorbike (motorcycle, minibike or ATV—all terrain vehicle)?					
C40. Wore a helmet when riding a motorbike?					
C41. Drove a car?					
C42. Wore a seat belt in a car or truck?					

Thinking about your home environment...

	No	Yes	Don't know
C43. Is there a working smoke detector or smoke alarm in your home?			
C44. Does anyone in your home smoke cigarettes?			
C45. Is there a working fire extinguisher in your home?			

C46. In general, is there a certain time of night when you have to be home on SCHOOL NIGHTS?

- ☐ Not usually permitted to go out on school nights
 ☐ Have to be in by 10:00 pm
☐ Have to be in by 8:00 pm
 ☐ No particular time
☐ Have to be in by 9:00 pm

In the PAST 4 WEEKS, how often did you eat the following types of foods...

	Rarely or never	A few days a month	Several days a week	About every day	More than once a day
C47. Fruits or vegetables?					
C48. Meat, chicken or fish that was not fried?					
C49. 2% or skim milk, or yogurt?					
C50. Grains and cereals like whole-wheat bread, bran cereals, or beans?					
C51. Fast foods, such as fried chicken, French fries, onion rings, and hamburgers?					
C52. Salty foods, such as salted pretzels, chips, or pickles?					
C53. Sweets such as regular soda, doughnuts, candy bars?					

This section is about health problems that you had in the **PAST 12 MONTHS**.

In the PAST 12 MONTHS, how many times did you have...

	None	Once	2 times	3 times	4 or more times
C54. A cold or flu?					
C55. Sinus trouble or sinusitis?					
C56. A sore throat or tonsillitis?					
C57. An ear infection?					
C58. Upset stomach with vomiting or diarrhea or fever?					
C59. Bronchitis?					
C60. A skin infection?					
C61. Pneumonia?					
C62. Infectious mononucleosis (mono)?					

Do you NOW have. . .

	No	Yes
C63. A vision problem?		
C64. A hearing problem?		

C65. About how many tooth cavities have you ever had?

- ☐ None
- ☐ 1 or 2 cavities
- ☐ 3 or 4 cavities
- ☐ 5 or more cavities
- ☐ Don't know

In the PAST 12 MONTHS, did you have any of the following injuries...

	No, never	Yes, but I DID NOT see a doctor or a nurse	Yes, and I DID see a doctor or a nurse
C66. A bad cut or sprain?			
C67. A bad sprain or torn ligament?			
C68. A broken bone, dislocated joint, or broken nose?			
C69. A bad head injury or concussion?			
C70. A bad burn?			

Thinking about your family, about how many days in the PAST 4 WEEKS did your parents or other adults in your family...

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
C71. Spend time with you doing something fun?					
C72. Talk with you or listen to your opinions and ideas?					
C73. Eat meals with you?					

REMEMBER, you can ask the Research Assistant, the Guidance Counselor, or the health care provider in the school clinic confidentially for help if you would like to.

You can also call any number in the brochure we will give to you to talk to someone about these issues.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY!

References

- Ackard, D.M., Eisenberg, M.A., and D. Neumark-Sztainer. (2007). Long-Term Impact of Adolescent Dating Violence on Behavioral and Psychological Health of Male and Female Youth. *The Journal of Pediatrics*, 151(5): pp. 476–81.
- Ackard, D.M., and D. Neumark-Sztainer. (2002). Date Violence and Date Rape among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health. *Child Abuse and Neglect*, 26(5): pp. 455–73.
- Ackard, D.M., and D. Neumark-Sztainer. (2003). Multiple Sexual Victimizations among Adolescent Boys and Girls: Prevalence and Associations with Eating Behaviors and Psychological Health. *Journal of Child Sexual Abuse*, 12(1): pp. 17–37.
- Ackard, D.M., Neumark-Sztainer, D., and P. Hannan. (2003). Dating Violence among a Nationally Representative Sample of Adolescent Girls and Boys: Associations with Behavioral and Mental Health. *Journal of Gender Specific Medicine*, 6(3): pp. 39–48.
- Arriaga, X.B., and V.A. Foshee (2004). Adolescent Dating Violence: Do Adolescents Follow in Their Friends', or Their Parents', Footsteps? *Journal of Interpersonal Violence*, 19(2): pp. 162–184.
- Ashley, O.S., and V.A. Foshee (2005). Adolescent Help-Seeking for Dating Violence: Prevalence, Sociodemographic Correlates, and Sources of Help. *Journal of Adolescent Health*, 36(1): pp. 25–31.
- Bandura, A. (1973). *Aggression: A Social Learning Analysis*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1977). *Social Learning Theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Banyard, V., Arnold, S., and J. Smith (2000). Childhood Sexual Abuse and Dating Experiences of Undergraduate Women. *Child Maltreatment*, 5(1): pp. 39–48.
- Bograd, M. (1999). Strengthening Domestic Violence Theories: Intersections of Race, Class, Sexual Orientation, and Gender. *Journal of Marital and Family Therapy* 25(3): pp. 275–289.
- Bossarte, R.M., Simon, T.R., and M.H. Swahn (2008). Clustering of Adolescent Dating Violence, Peer Violence, and Suicidal Behavior. *Journal of Interpersonal Violence*, 23(6): pp. 815–833.
- Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.
- Bureau of Justice Statistics (1996). National Crime Victimization Survey. Washington, DC: U.S. Department of Justice.
- Bureau of Justice Statistics (1997). Sex Offenses and Offenders. Washington, DC: U.S. Department of Justice.
- Bureau of Justice Statistics (2001). Special Report: Intimate Partner Violence and Age of Victims, 1993–99. Washington, DC: U.S. Department of Justice.
- Catalano, Shannan (2004). Criminal Victimization, 2003. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Online: <http://www.ojp.usdoj.gov/bjs/abstract/cv03.htm>.
- Centers for Disease Control (CDC) National Center for Injury Prevention and Control (NCIPC) (2008). *Dating Abuse Fact Sheet*. Retrieved on March 24, 2008, from <http://www.cdc.gov/ncipc/dvp/DatingViolence.htm>.
- Centers for Disease Control (CDC) (2006). Physical Dating Violence among High School Students: United States, 2003. *Morbidity and Mortality Weekly Report*, 55(19): pp. 532–535.
- Centers for Disease Control (CDC) (2006). Youth Risk Behavior Surveillance: United States, 2005. Surveillance Summaries. *Morbidity and Mortality Weekly Report*, 55(S-5): pp.1–108.
- Center for Problem-Oriented Policing. *Domestic Violence: Guide No. 45* (2006). Retrieved July 19, 2008, from http://www.popcenter.org/problems/domestic_violence/.
- Cohall, A., Cohall, R., and H. Bannister (1999). A Love

- Shouldn't Hurt: Strategies for Healthcare Providers to Address Adolescent Dating Violence. *Journal of the American Medical Women's Association*, 54(3): 144–148.
- Cohen, L., and S. Swift (1999). The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention. *Injury Prevention*, 5(3): pp. 203–207.
- Currie, D.W. (1983). A Toronto Model. *Social Work with Groups* 6: pp. 179–188.
- Davidson, L.L. (2004). *Prevalence of Intimate Partner Violence in Urban Young Women: Experiences with Disclosure in Healthcare Settings*. Washington, DC: American Public Health Association Conference Presentation.
- Deomampo, D. (2007). *Sexual Victimization of Youth Nationwide and in New York City: A Systematic Narrative Review*. New York: New York City Alliance Against Sexual Assault.
- Diaz, A., Edwards, S., Neal, W. P., Ludmer, P., Sondike, S. B., Kessler, C., Medeiros, D., and N.T. Nucci (2004). Obtaining a History of Sexual Victimization from Adolescent Females Seeking Routine Healthcare. *The Mount Sinai Journal of Medicine*, 71: pp.170–451.
- Donovan, J. E., and Jessor, R. (1985). Structure of Problem Behavior in Adolescence and Young Adulthood. *Journal of Consulting and Clinical Psychology* 53: pp. 890–904.
- DuMont, J., Miller, K-L., and T.L. Myhr (2003). The Role of “Real Rape” and “Real Victim” Stereotypes in the Police Reporting Practices of Sexually Assaulted Women. *Violence Against Women*. 9(4): pp. 466–486.
- Dunlap, E., Golub, A., and B.D. Johnson (2003). Girls' Sexual Development in the Inner City: from Compelled Childhood Sexual Contact to Sex-for-Things Exchanges. *Journal of Child Sexual Abuse*, 12: pp. 73–96.
- Eastwood, E.A., and J.M. Birnbaum (2007). Physical and Sexual Abuse and Unstable Housing among Adolescents with HIV. *AIDS and Behavior*, 11(S2): pp. 116–127.
- Eaton, D.K., Davis, K.S., Barrios, L., Brener, N.D., and R.K. Noonan (2007). Associations of Dating Violence Victimization with Lifetime Participation, Co-Occurrence, and Early Initiation of Risk Behaviors among U.S. High School Students. *Journal of Interpersonal Violence*, 22(5): pp. 585–602.
- Ellsburg, M., and L. Heise (2005). *Research Violence against Women: A Practical Guide for Researchers and Activists*. Geneva: World Health Organization (WHO) and the Program for Appropriate Technology in Health (PATH).
- Finkelhor, David (1994). Current Information on the Scope and Nature of Child Sexual Abuse. *The Future of Children*, 4(2): pp. 31–53.
- Finkelhor, D., Ormrod, R.K., and H.A. Turner (2007a). Polyvictimization: A Neglected Component in Child Victimization. *Child Abuse & Neglect*, 31(1): pp. 7–26.
- Finkelhor, D., Ormrod, R.K., and H.A. Turner (2007b). Polyvictimization and Trauma in a National Longitudinal Cohort. *Development and Psychopathology*, 19(1): pp. 149–166.
- Finkelhor, D., Ormrod, R.K., Turner, H., and S.L. Hamby (2005). The Victimization of Children and Youth: A Comprehensive National Survey. *Child Maltreatment*, 10(5): pp. 5–25.
- Foshee, V.A., (1996). Gender Differences in Adolescent Dating Abuse Prevalence, Types, and Injuries. *Health Education Research* 11 (3): pp. 275–286.
- Foshee, V.A. et al. (1996). The Safe Dates Project: Theoretical Basis, Evaluation Design, and Selected Baseline Findings. *American Journal of Preventive Medicine*, 12(5): pp. 39–47.
- Foshee, V.A., Benefield, T.S., Ennett, S.T., Bauman, K.E., and C. Suchindran (2004). Longitudinal Predictors of Serious Physical and Sexual Dating Violence Victimization During Adolescence. *Preventive Medicine*, 39(5): pp. 1007–16.
- Foshee, V.A., Linder, F., MacDougall, J.E., and S. Bangdiwala (2001). Gender Differences in the Longitudinal Predictors of Adolescent Dating Violence. *Preventive Medicine*, 32(2): pp. 128–141.
- Freudenberg, N., Roberts, L., Richie, B. E., Taylor, R. T., McGillicuddy, K., and M.B. Greene (1999). Coming Up in the Boogie Down: The Role of Violence in the Lives of Adolescents in the South Bronx. *Health Education & Behavior*, 26: pp. 788–805.
- Fujie-Parks, L., Cohen, L., and N. Kravitz-Wirtz (2007). *Poised for Prevention: Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence*.

California: Prevention Institute.

Garcia-Moreno, C., Jansen, H.A., Ellsberg, M., Heise, L., and C. Watts (2005). *WHO Multicountry Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes, and Women's Responses*. Geneva: World Health Organization.

Gidycz, C.A., Orchowski, L.M., King, C.R., and C.L. Rich (2008). Sexual Victimization and Health-Risk Behaviors: A Prospective Analysis of College Women. *Journal of Interpersonal Violence*, 23(6): pp. 744–63.

Greenfield, L.A. (1996). *Child Victimizers: Violent Offenders and Their Victims*. Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.

Guerny, B., Jr., Waldo, M., and Firestone, L. (1987). Wife Battering: A Theoretical Construct and Case Report. *American Journal of Family Therapy* 15: pp. 34–43.

Harner, H. (2000). Sexual Violence and Adolescents. Applied Research Forum: National Online Resource Center on Violence Against Women. Accessed on March 15, 2008, at www.vawnet.org/SexualViolence/Research/VAWnetDocuments/AR_Adolescents.pdf.

Hayes, Robert (1990 Summer). Child Sexual Abuse. *Crime Prevention Journal*.

Hokoda, A., Ramos-Lira, L., Celaya, P., Vilhauer, K., Angeles, M., Ruiz, S., Malcarne, V.L., and M. Duque Mora (2006). Reliability of Translated Measures Assessing Dating Violence among Mexican Adolescents. *Violence and Victims*, 21(1): pp. 117–127.

Holtzworth-Munroe, A., and Stewart, G. (1994). Typologies of Male Behaviors: Three Subtypes and the Differences among Them. *Psychological Bulletin*, 116: pp. 476–497.

Horwitz, A. (1990). *The Logic of Social Control*. New York: Plenum Press.

Howard, D.E., Beck, K., Kerr, M.H., and T. Shattuck (2005). Psychological Correlates of Dating Violence Victimization among Latino Youth. *Adolescence*, 40(158): pp. 319–31.

Howard, D.E., and M.Q. Wang (2003). Psychological Factors Associated with Adolescent Boys' Reports of

Dating Violence. *Adolescence*, 38(151): pp. 519–33.

Howard, D.E., Wang, M.Q., and F. Yan (2007). Psychological Factors Associated with Reports of Physical Dating Violence among U.S. Adolescent Females. *Adolescence*, 42(166): pp. 311–24.

Jaffe P., Sudermann M., Reitzel D., and S. Killip (1992). An Evaluation of a Secondary School Primary Prevention Program on Violence in Intimate Relationships. *Violence and Victims*, 7: pp. 129–46.

Jewkes, R., Sen, P., and C. Garcia-Moreno (2002). *Sexual Violence*. In: Krug, E., Dahlberg, L., Mercy, J.A., Zwi, A.B., and R. Lozano (2002). *World Report on Violence and Health*. Geneva: World Health Organization.

Jezl, D. R., Molidor, C.E., and T.L. Wright (1996). Physical, Sexual, and Psychological Abuse in High School Dating Relationships: Prevalence Rates and Self-Esteem Issues. *Child and Adolescent Social Work Journal*, 13(1): pp. 69–87.

Kilpatrick, D.G., Saunders, B.E., and D.W. Smith (2003). *Youth Victimization: Prevalence and Implications*. Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice.

Krogan, S. (2004). Disclosing Unwanted Sexual Experiences: Results from a National Sample of Adolescent Women. *Child Abuse and Neglect*, 28(2): pp. 147–165.

Matsakis, Aphrodite (1991). *When the Bough Breaks*. Oakland, CA: New Harbinger Publications.

Mayor's Office to Combat Domestic Violence (MOCADV) (2006). *Domestic Violence Fact Sheet*. New York: New York.

Molider, C., and R.M. Tolman (1998). Gender and Contextual Factors in Adolescent Dating Violence. *Violence against Women*, 4(2): pp. 180–94.

Molnar, B. E., Shade, S. B., Kral, A. H., Booth, R. E., and J.K.Watters (1997). Suicidal Behavior and Sexual/Physical Abuse among Street Youth. *Child Abuse & Neglect*, 22: pp. 213–222.

National Coalition against Domestic Violence (NCADV) (2008). *Dating Violence*. Retrieved on March 24, 2008, from <http://www.ncadv.org/files/datingviolence.pdf>.

- New York City Departments of Health and Mental Hygiene (DOHMH) and Education (DOE): New York City Youth Risk Behavior Survey, 2007; data requested from DOHMH Bureau of Epidemiology Services, June 2008.
- Noll, J.G., Horowitz, L.A., Bonano, G.A., Trickett, P.K., and F.W. Putnam (2003). Revictimization and Self-Harm in Females who Experienced Childhood Sexual Abuse. *Journal of Interpersonal Violence*, 18(12): pp. 1452–1471.
- Ocampo, B.W., Shelley, G.A., and L.H. Jaycox (2007). Latino Teens Talk about Help-Seeking and Help-Giving in Relation to Dating Violence. *Violence against Women*, 13(2): pp. 172–189.
- Oetting, E.R., Donnermeyer, J.F., Plested, B.A., Edwards, R.W., Kelly, K., and F. Beauvais (1995). Assessing Community Readiness for Prevention. *International Journal of Addictions*, 30(6): pp. 659–683.
- Olshen, E., McVeigh, K.H., Wunsch-Hitzig, R.A., and V.I. Rickert (2007). Dating Violence, Sexual Assault, and Suicide Attempts among Urban Teenagers. *Archives of Pediatric and Adolescent Medicine*, 161(6): pp. 539–545.
- Ozer, E.J., Tschann, J.M., Pasch, L.A., and E. Flores. (2004) Violence Perpetration across Peer and Partner Relationships: Co-occurrence and Longitudinal Patterns across Adolescents. *Journal of Adolescent Health*, 34(1): pp. 64–71.
- Pan American Health Organization (PAHO). Factsheet: Women, Health and Development Program. Accessed on March 22, 2008, at: <http://www.paho.org/English/DPM/GPP/GH/VAW2003.pdf>.
- Plested, B.A., Edwards, R.W., and P. Jumper-Thurman (2005). *Community Readiness: A Handbook for Successful Change*. Fort Collins, CO: Tri-Ethnic Center for Prevention Research.
- Population Information Program (2000). *Population Reports: Ending Violence against Women*. Baltimore, MD: Johns Hopkins School of Public Health and Center for Healthcare Gender Equity.
- Raj, A., Reed, E., Miller, E., Decker, M.R., Rothman, E.F., and J.G. Silverman (2007). Contexts of Condom Use and Noncondom Use among Young Adolescent Male Perpetrators of Dating Violence. *AIDS Care*, 19(8): pp. 970–973.
- Rennison, C. (2002). *Criminal Victimization, 2001: Changes 2000–01 with Trends, 1993–2001*. National Crime Victimization Survey. Washington, DC: Bureau of Justice Statistics.
- Rickert, V.I., Davidson, L.L., Fry, D.A., and N. Palmetto (2008). *Impact of Dating Violence Experiences on Adolescent Health and Wellbeing*. Society of Adolescent Medicine Conference, March 26–29, 2008. Greensboro: North Carolina.
- Rickert, V.I., Wiemann, C.M., and R.D. Vaughan (2005). Disclosure of Date/Acquaintance Rape: Who Reports and When. *Journal of Pediatric and Adolescent Gynecology*, 18(1): pp. 17–24.
- Rickert, V. I., Wiemann, C. M., Vaughan, R. D., and J.W. White (2004). Rates and Risk Factors for Sexual Violence among an Ethnically Diverse Sample of Adolescents. *Archives of Pediatrics & Adolescent Medicine*, 158, pp. 1132–1139.
- Riley, A.W., Green, B., Forrest, C.B., Starfield, B., Kang, M., Ensminger, M. (1998). A Taxonomy of Adolescent Health: Development of the Adolescent Health Profile Types. *Medical Care*, 36: pp. 1228–1236.
- Ryan, G., Miyoshi, T.J., Metzner, J.L., Krugman, R.D., and G.E. Fryer (1996). Trends in a National Sample of Sexually Abusive Youths. *Journal of the American Academy of Adolescent Psychiatry*, 35(1): pp. 17–25.
- Sable, M.R., Danis, F., Mauzy, D.L., and S.K. Gallagher (2006). Barriers to Reporting Sexual Assault for Women and Men: Perspectives of College Students. *Journal of American College Health*, 55(3): pp. 157–162.
- Saltzman, L.E., Fanslow, J.L., McMahon, P.M., and G.A. Shelley (2002). *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements*. Atlanta: Centers for Disease Control.
- Silverman, J.G., Raj, A., and K. Clements (2004). Dating Violence and Associated Sexual Risk and Pregnancy among Adolescent Girls in the United States. *Pediatrics*, 114(2): pp. e220–5.
- Silverman, J.G., Raj, A., Mucci, L.A., and J.E. Hathaway (2001). Dating Violence against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. *JAMA: Journal of the American Medical Association*, 286(5): pp. 572–579.

Swahn, M.H., Simon, T.R., Hertz, M.F., Arias, I., Bossarte, R.M., Ross, J.G., Gross, L.A., Iachan, R., and M.E. Hamburger. Linking Dating Violence, Peer Violence, and Suicidal Behaviors among High-Risk Youth. *American Journal of Preventive Medicine*, 34(1): pp. 30–38.

Symons, P.Y., Groer, M.W., Kepler-Youngblood, P., and V. Slater (1994). Prevalence and Predictors of Adolescent Dating Violence. *Journal of Child and Adolescent Psychiatric Nursing*, 7(3): pp. 14–23.

Tjaden, P., and N. Thoennes (1998). *Prevalence, Incident, and Consequences of Violence against Women: Findings from the National Violence against Women Survey*. Washington, DC: National Institute of Justice, Office of the Justice Programs, U.S. Department of Justice.

Turner, Jeffrey S. (1996). *Encyclopedia of Relationships across the Lifespan*. Greenwood Publishing Group, p. 92.

Weisz, A.N., Tolman, R.M., Callahan, M.R., Saunders, D.G., and B.M. Black (2006). Informal Helpers' Responses When Adolescents Tell Them about Dating Violence or Romantic Relationship Problems. *Journal of Adolescence*, 30(5): pp. 853–868.

White, G.W., Suchowierska, M., and M. Campbell (2004) Developing and Systematically Implementing Participatory Action Research. *Archives of Physical Medicine and Rehabilitation*, 85 (suppl2): pp. S3–12.

Wilt, S., Illman, S., and M. Brodyfield (1996). *Female Homicide Victims in New York City, 1990–1994*. New York City Department of Health and Mental Hygiene: New York.

Wolfe, D.A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., and A.L. Pittman (2001). Development and Validation of the Conflict in Adolescent Dating Relationships Inventory. *Psychological Assessment*, 13: pp. 277–293.

Zeitler, M.S., Paine, A.D., Breitbart, V., Rickert, V.I., Olson, C., Stevens, L., Rottenberg, L., and Davidson, L.L. (2006) *Attitudes about Intimate Partner Violence Screening among an Ethnically Diverse Sample of Young Women*. *J Adol Medicine* (2006) 39: pp. 119. e1–119.e8.

We Need Your Help ► Because Sexual Violence Is Still a Problem.

The New York City Alliance Against Sexual Assault develops and advances strategies, policies, and responses that prevent sexual violence and limit its destabilizing effects on victims, families, and communities. As the only sexual violence organization in the country conducting citywide primary research on sexual violence, we are in a unique position to raise public awareness and

create sustainable change. Our work is made possible by the generous contributions of people like you; people who share the commitment of engaging all communities in addressing sexual violence. Together we can ensure survivors of sexual violence receive the best care and dare to envision a world without sexual violence. All we need is you! Please give today.

Please select how you would like to direct your gift:

- ☐ **Give to the Alliance/Community Fund**
- ☐ Innovative Research
- ☐ Immigrant Women
- ☐ Youth
- ☐ Survivor Access to Best Care
- ☐ Training and Education
- ☐ Sexual Violence Resource Leader
- ☐ Legislative Advocacy
- ☐ Community Organizing
- ☐ SAYSO!

Please select your gift amount:

- ☐ \$25 ☐ \$50 ☐ \$100 ☐ \$250
- ☐ \$500 ☐ \$1,000 ☐ Other \$ _____

Name _____

Address _____

City _____

State _____

Zip _____

Daytime Phone _____

Email Address _____

The New York City Alliance Against Sexual Assault is a 501(c)(3) corporation. Gifts are fully tax-deductible to the extent of the law.

Payment Method:

- ☐ Check or money order payable to the
New York City Alliance Against Sexual Assault

Credit card (check one)

- ☐ MasterCard ☐ VISA ☐ Amex ☐ Discover

Card number _____

Expiration Date and Credit Card Security Code (CSC) _____

Today's Date _____

Name on Card _____

Billing Address ☐ same as opposite column

Address _____

City _____

State _____

Zip _____

I would like my contribution to be in honor of: _____

I would like my contribution to be in memory of: _____

Fax your completed form to **212.229.0676**
or mail it to:

New York City Alliance Against Sexual Assault
27 Christopher Street, 3rd Floor
New York, NY 10014

To learn more about the Alliance or to donate online,
please visit **www.nycagainstrape.org**



New York City Alliance
Against Sexual Assault



Columbia Center for Youth Violence Prevention

2008–2009

BOARD OF DIRECTORS

Ben Monachino, Board Chair
Mary Anderson
Madeline Bryer
Larry Busching
Erica Garcia
Richard Glover
Nathan Lubow
Jennifer Mercurio
Kristina Pappa
Mel Schneiderman
Shirley Traylor
Hope Wachter
Susan Xenarios

PROJECT STAFF

NYC Alliance Against Sexual Assault

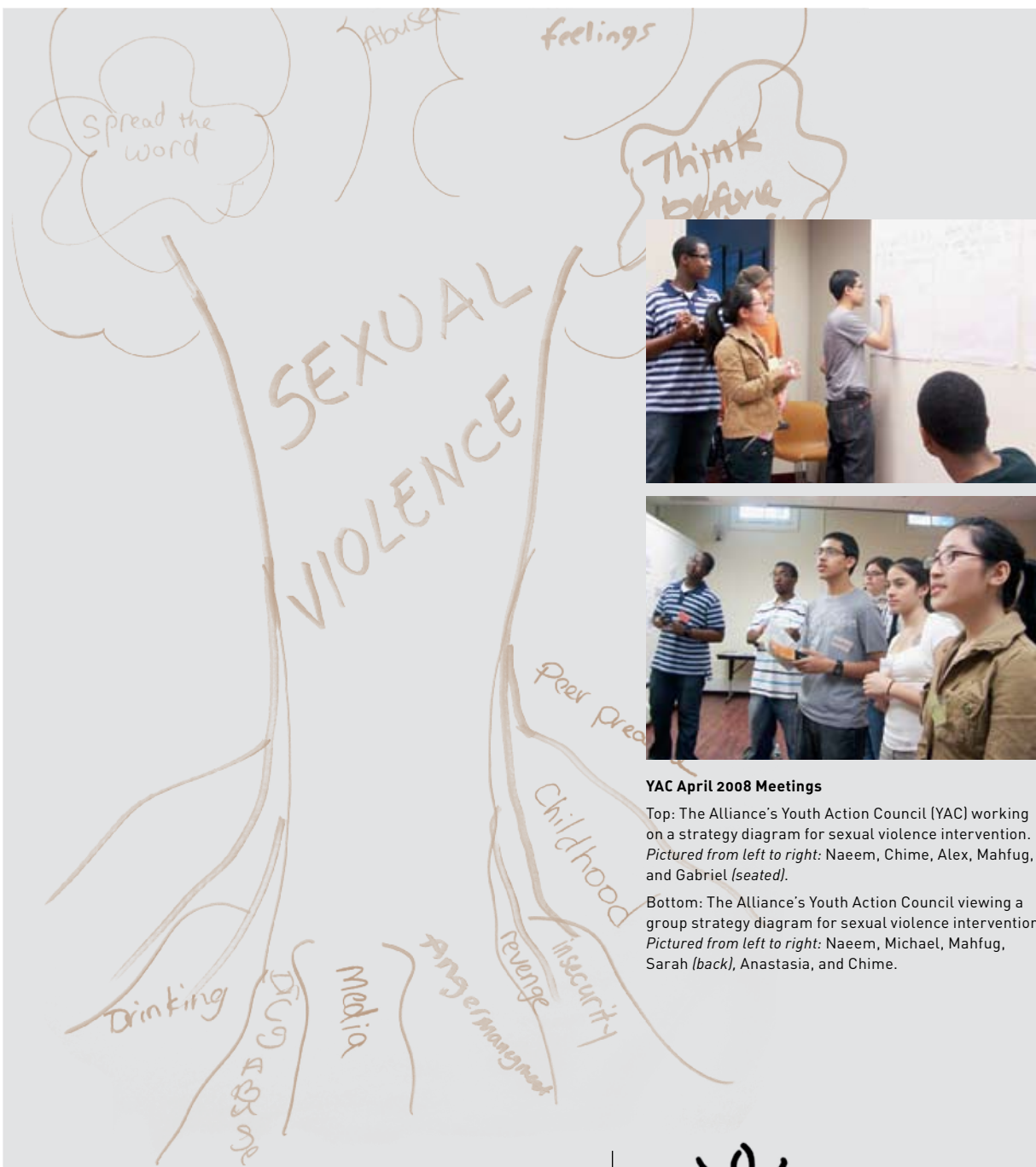
Deborah Fry, Principal Investigator
Harriet Lessel, Executive Director
Mónica G. Paz, Research Associate
Daisy Deomampo, Research Associate
Tamara Pollak, Research Assistant
Meghan O'Connor, Director of Programs
Christy Banister, Data Entry Intern
Sylvan Rosas, Data Entry Intern
Erin Hopkins, Data Entry Intern
Lauren Lorek, Policy Social Work Student
McKenna Knych, Intern

Columbia Center for Youth Violence Prevention

Leslie L. Davidson, Principal Investigator
Vaughn I. Rickert, Coinvestigator
Niki Palmetto, Research Assistant
Saroj Sedalia, Research Assistant
Elizabeth Richards, Data Entry Intern

CONSULTANTS

Teresa Román, Spanish Translator, Portada LLC
The Language Lab & Translation Company of America
William Bacon, ACASI Programmer
Scott Santoro, Graphic Designer, Worksight
Stacie Joy, Editor



YAC April 2008 Meetings

Top: The Alliance's Youth Action Council (YAC) working on a strategy diagram for sexual violence intervention. Pictured from left to right: Naeem, Chime, Alex, Mahfug, and Gabriel (seated).

Bottom: The Alliance's Youth Action Council viewing a group strategy diagram for sexual violence intervention. Pictured from left to right: Naeem, Michael, Mahfug, Sarah (back), Anastasia, and Chime.



**New York City Alliance
Against Sexual Assault**



Columbia Center for Youth Violence Prevention

NYC Alliance Against Sexual Assault
27 Christopher Street
3rd Floor
New York, NY 10014
212.229.0345 phone
212.229.0676 fax
research@nycagainstrape.org
www.nycagainstrape.org

Publication 3

Messinger, A.M., Rickert, V.I., Fry, D.A., Lessel, H. and Davidson, L.L. (2012). Revisiting the Role of Communication in Adolescent Intimate Partner Violence. *Journal of Interpersonal Violence*, 27(14): 2851-2866.

Copyright permission obtained from SAGE Publications and the co-authors of this publication to use and archive this journal article within this PhD by Publications thesis.

Journal of Interpersonal Violence

<http://jiv.sagepub.com/>

Revisiting the Role of Communication in Adolescent Intimate Partner Violence

Adam M. Messinger, Vaughn I. Rickert, Deborah A. Fry, Harriet Lessel and
Leslie L. Davidson

J Interpers Violence 2012 27: 2920 originally published online 4 April 2012
DOI: 10.1177/0886260512438276

The online version of this article can be found at:
<http://jiv.sagepub.com/content/27/14/2920>

Published by:



<http://www.sagepublications.com>

On behalf of:

[American Professional Society on the Abuse of Children](#)

Additional services and information for *Journal of Interpersonal Violence* can be found at:

Email Alerts: <http://jiv.sagepub.com/cgi/alerts>

Subscriptions: <http://jiv.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations: <http://jiv.sagepub.com/content/27/14/2920.refs.html>

>> [Version of Record](#) - Aug 28, 2012

[OnlineFirst Version of Record](#) - Apr 4, 2012

Revisiting the Role of Communication in Adolescent Intimate Partner Violence

Journal of Interpersonal Violence

27(14) 2920–2935

© The Author(s) 2012

Reprints and permission:

sagepub.com/journalsPermissions.nav

DOI: 10.1177/0886260512438276

<http://jiv.sagepub.com>



**Adam M. Messinger¹, Vaughn I. Rickert²,
Deborah A. Fry³, Harriet Lessel⁴,
Leslie L. Davidson⁵**

Abstract

A growing literature suggests that communication strategies can promote or inhibit intimate partner violence (IPV). Research on communication is still needed on a group ripe for early IPV intervention: high school-aged adolescents. This article revisits our previous analyses of young female reproductive clinic patients (Messinger, Davidson, & Rickert, 2011) by examining how the adolescent and young adult respondents differ. To explore replicability of the adolescent results across populations, they are compared to 487 adolescent female students sampled from four urban high schools. Across samples, all communication strategies were used more frequently within violent relationships. Multivariate analysis identified escalating strategies used and received as being positively associated with physical violence used and received in all three samples. Regarding verbal reasoning and temporary conflict avoidance, substantial differences appeared between the young adult and adolescent clinic samples, and results from the adolescent clinic sample were

¹Northeastern Illinois University, Chicago, IL, USA

²Indiana University School of Medicine and Riley Hospital for Children, Indianapolis, IN, USA

³University of Edinburgh, Edinburgh, UK

⁴The New York City Alliance Against Sexual Assault, New York, NY, USA

⁵Columbia University, New York, NY, USA

Corresponding Author:

Adam M. Messinger, Justice Studies Department, Northeastern Illinois University, 5500 North St. Louis Avenue, Lech Walesa Hall room 4062, Chicago, IL, 60625, USA
Email: amess002@gmail.com

largely replicated with the adolescent school sample, suggesting that young adult samples in this literature are not adequate proxies for adolescents.

Keywords

dating violence, domestic violence, predicting domestic violence

Quantitatively-oriented scholars of intimate partner violence (IPV) have given less attention to relationship communication than other IPV predictors, perhaps due to the challenges in operationalizing communication (Lloyd, 1990; Ridley & Feldman, 2003; Sabourin, 1996). A prominent theory contends that communication strategies are often perceived as resources to “win” conflicts, such that, when verbal reasoning fails, escalating communications may be turned to, and, if necessary, violence can become a final resort (for a review, see Messinger et al., 2011). Cross-sectional data suggests verbal reasoning does help defuse conflict and the potential for violence, whereas *escalating strategies*—verbal aggression and controlling tactics—escalate conflicts to violence (Billingham & Sack, 1986; Bird, Stith, & Schladale, 1991; Cornelius, Shorey, & Beebe, 2010; Gryl, Stith, & Bird, 1991; Josephson & Proulx, 2008; Messinger et al., 2011; Ridley & Feldman, 2003). Furthermore, evidence indicates that temporary conflict avoidance is not associated with physical violence (Messinger et al., 2011). A limited number of studies find youth in violent relationships use both escalating strategies (Billingham & Sack, 1986; Messinger et al., 2011; Ridley & Feldman, 2003) and temporary avoidance strategies (Messinger et al., 2011) more frequently than youth in nonviolent relationships. Perhaps this is due to violent relationships encountering both more conflicts and more serious conflicts than nonviolent relationships (Gryl et al., 1991). Each type of communication strategy tends to be reciprocated in youth relationships (Messinger et al., 2011), as is physical violence (Fernandez & Fuertes, 2010; O’Leary, Smith Slep, Avery-Leaf, & Cascardi, 2008) though it is debated whether this implies mutual battering or violence in self-defense (Williams, Ghandour, & Kub, 2008).

Analyses on a range of communication strategies as predictors of physical IPV have been conducted on marital, college-aged, and middle school populations, but only one such article used a sample of high school-aged adolescents. In their recent survey of 618 female reproductive clinic patients aged 15 to 24, Messinger et al. (2011) found that physical violence used and received in opposite-sex relationships were positively associated with escalating strategies and negatively associated with verbal reasoning by either

partner (with the exception of nonsignificance for reasoning used predicting violence used), while avoidance was not associated with violence in any model.

However, by pooling together such a broad age spectrum, it may be that age-related differences were aggregated and masked. The literature hints that developmental processes may affect relationship communication pathways. For example, interpersonal communication styles are known to shift during adolescence (Laursen & Collins, 1994), and some evidence suggests that high school-aged females are far more “dismissive” (i.e. avoidant) and insecurely jealous or “preoccupied” (i.e. escalating) than college-aged females, while “secure” relationship styles (likely involving more verbal reasoning) are more equally distributed across age groups (Furman & Wehner, 1997). Relationship contexts, which may affect triggers to conflict, are also known to vary by age, including the relationship length and importance, prior relationship experience, and degree of sexual intimacy (Furman & Wehner, 1997). Furthermore, age is associated with the prevalence (Rennison, 2001) and mutuality of violence (Morse, 1995), as are marital and cohabitation status (Stets & Straus, 1990), again hinting at developmental variations in IPV relationships. If indeed relationship communication pathways are affected by a developmental process, previous IPV communications research on young adults cannot be generalized to apply to adolescents. This possibility underscores the need for IPV communication research on high school-aged adolescents, a population ripe for early monitoring and intervention (O’Leary, 1999; Rennison, 2001; Rivara et al., 2009).

The present article aimed to isolate the role of relationship communication in IPV among female adolescents by examining differences between the 15- to 19-year-old female adolescents and the 20- to 24-year-old female young adults in Messinger et al.’s (2011) previous sample of female clinic patients. To explore replicability of the adolescent findings across populations, the adolescent female clinic patients are then compared to a sample of 14- to 19-year-old female adolescent students from four high schools. Based on the literature, we developed three hypotheses. First, we predicted that all communication strategies would be used and received more frequently in violent relationships. Second, we predicted that adolescent females would report using more avoidant and escalating strategies than young adult females. Third, in the absence of preexisting empirical evidence, we also predicted that each of our samples would closely follow results from our prior work in that physical violence used and received would be positively associated with escalating strategies used and received, negatively associated with verbal reasoning used and received, and not associated with avoidance used or received.

Method

To test the above hypotheses, three samples were used. The first two samples are drawn from a single larger group of 618 female reproductive health clinic patients aged 15 to 24 who had experienced an opposite-sex dating relationship in the past year. After being recruited by staff members, respondents completed an anonymous survey through ACASI (audio computer-assisted self-interviewing) and were compensated with a US\$10 gift certificate (for additional study methodology, see Messinger et al., 2011). The present article categorized this group into a “young adult clinic sample”—320 female patients 20 to 24 years old—and an “adolescent clinic sample”—298 female patients 15 to 19 years old. The third sample is from a larger study of 1,454 male and female students from four urban high schools in the same city as the clinic, recruited through passive parental consent and student assent or consent. Students were given an ACASI or paper-and-pencil questionnaire version, each participant being compensated with a US\$10 gift card (for a complete methodology report, see Fry, Davidson, Rickert, & Lessel, 2008). Of the 790 female students, this article analyzes the 487 adolescent females aged 14 to 19 who reported having had an opposite-sex dating relationship in the past year, termed the “adolescent school sample.” The male students were excluded from analyses both to strengthen comparisons with the all-female clinic sample and because the male students may have been referring to the same relationships as female students, thus artificially weighting results. By employing these three samples, this article aims to, first, distinguish which results are age-specific for adolescents as compared to young adults and, second, whether these adolescent findings are robust across differing population samples.

Identical variables, coding, and analyses were used for all three samples. The two dependent variables, the frequency of physically violent behaviors used and received, are each subscales drawn from the Conflict in Adolescent Dating Relationships Inventory (CADRI; Wolfe et al., 2001). Four item pairs asked if the respondent and the respondent’s partner used the following behaviors: threw something at; pushed, shoved, or shook; slapped or pulled the hair of; or kicked, hit, or punched the other partner. Possible responses were zero times (coded 0), 1 to 2 times (coded 1), 3 to 5 times (coded 2), or six or more times (coded 3). These items were summed to create scales for the use and receipt of physical violence. Also drawn from the CADRI (Wolfe et al., 2001), the six main independent variables include the amounts of verbal reasoning used and received (e.g., “offered a solution that I thought would make us both happy”), temporary conflict avoidance used and received (e.g., “put off talking until we calmed down”), and escalating strategies used and received, which is a combination of movement-restricting controlling strategies

(e.g., “kept track of who s/he was with and where s/he was”) and verbally aggressive strategies (e.g., “said things just to make him/her angry”). These key independent variables are scored the same way as the physical violence dependent variables. Verbal reasoning and temporary conflict avoidance, originally a single submeasure of the CADRI, were treated as separate constructs because evidence suggests that they have very distinct impacts on violence in relationships (see Messinger et al., 2011). Cronbach’s alpha reliability coefficients were strong for violence used (young adult clinic sample, adolescent clinic sample, and adolescent school sample: $\alpha = .88, .82$, and $.84$ respectively) and received ($\alpha = .87, .87$, and $.86$), escalation strategies used ($\alpha = .89, .86$, and $.86$) and received ($\alpha = .90, .88$, and $.85$), and reasoning used ($\alpha = .86, .78, .78$) and received ($\alpha = .84, .79$, and $.78$), while reliability was more modest for avoidance used ($\alpha = .65, .61$, and $.52$) and received ($\alpha = .66, .64$, and $.46$). Last, several known predictors of IPV were controlled for, including experiencing child sexual abuse, relationship importance, relationship length, number of pregnancies, age, and race-ethnicity. Since the CADRI inquires only about the previous year, analyses were adjusted with an exposure time variable assessing the number of months a relationship existed within the past year.

There were no missing data in the adolescent and young adult clinic samples. In the adolescent school sample, there were missing cases for physical violence used ($n = 1$) and received ($n = 34$), reasoning used ($n = 17$) and received ($n = 41$), avoidance used ($n = 7$) and received ($n = 38$), escalation used ($n = 30$) and received ($n = 44$), experiencing child sexual abuse ($n = 14$), relationship importance ($n = 4$) and length ($n = 2$), times pregnant ($n = 13$), race-ethnicity variables ($n = 59$), and months exposed to the CADRI time frame ($n = 12$). Adolescent school data was missing at random (MAR) rather than missing completely at random (MCAR), with missingness on several of the communication variables significantly associated with lower mean scores on other communication and violence variables (t tests, $p < .05$). Pairwise deletion of missing cases was used for bivariate descriptive analysis of the adolescent school data. However, to account for patterns of missingness in multivariate analysis of the adolescent school sample, we employed STATA’s ICE program (Royston, 2009), where multiple imputed data sets with five iterations were generated for each model analyzed, each time using all the variables for that given model during the imputation process.

Following Messinger et al.’s (2011) approach, for multivariate analyses, the three samples were each divided into two overlapping subsamples: the first subsamples included respondents who, in the past year, used physical violence (young adult clinic subsample No. 1, $n = 88$; adolescent clinic subsample No. 1, $n = 108$; adolescent school subsample No. 1, $n = 215$) and, for



comparison, those who neither used nor received violence (young adult clinic subsample No. 1, $n = 225$; adolescent clinic subsample No. 1, $n = 181$; adolescent school subsample No. 1, $n = 239$), and the second set of subsamples included respondents who, in the past year, received violence (young adult clinic subsample No. 2, $n = 64$; adolescent clinic subsample No. 2, $n = 72$; adolescent school subsample No. 2, $n = 136$) and, again, the same respondents from the first subsamples who neither used nor received violence. Violence users and receivers were never directly compared because of the considerable number falling into both groups (young adult clinic sample, $n = 57$; adolescent clinic sample, $n = 63$; adolescent school sample, $n = 128$).

Each use-receipt communication variable set was split into separate models for multivariate analysis due to strong multicollinearity within each set (within-set correlations: young adult clinic sample, $r = .73-.88$; adolescent clinic sample, $r = .63-.89$; adolescent school sample, $r = .71-.87$) and far lower correlation coefficients for bivariate associations across strategy types. The communication variables were assigned models to replicate Messinger et al.'s (2011) approach so as to increase the strength of cross-paper comparisons; in addition, these models reflect the literature's assertion that escalating strategies are often perceived as a means to gain control relative to a less contentious approach like reasoning or avoidance. Specifically, negative binomial regression, suited for dependent variables measuring an event frequency for which the probability of occurrence shifts over time, was conducted on four models to see if (M1) escalating strategies *used* and avoidance and reasoning *received* affect physical violence *used by the young women*, if (M2) escalating strategies *used* and avoidance and reasoning *received* affect violence *received*, if (M3) escalating strategies *received* and avoidance and reasoning *used* affect violence *used*, and if (M4) escalating strategies *received* and avoidance and reasoning *used* affect violence *received*. Models include all aforementioned control variables and were adjusted for exposure to the CADRI's time frame. Consistent with Messinger et al.'s (2011) analytic approach, Models M1 and M3 were run with the young adult clinic subsample No. 1, adolescent clinic subsample No. 1, and adolescent school subsample No. 1 (violence used by the women), and Models M2 and M4 were run with the young adult clinic subsample No. 2, adolescent clinic subsample No. 2, and adolescent school subsample No. 2 (violence received by the women).

Results

Demographically, the young adult clinic sample had a mean age of 22.04 years, 25% of the sample reported Latino descent, and, regarding race, 28% of the sample was Black, 32% White, and 12% Asian American. Our adolescent

Table 1. Comparing Means, Standard Deviations, and Correlation Matrices for the Young Adult Clinic, Adolescent Clinic, and Adolescent School Female Samples

Variables	1	2	3	4	5	6	7	8	Sample
1. Physical used	—	0.68*	0.28*	0.33*	0.23*	0.17*	0.53*	0.57*	Clinic
2. Physical rec	0.59*	—	0.20*	0.23*	0.15*	0.02	0.43*	0.57*	20-24 yo, N = 320
3. Avoidance used	0.18*	0.12*	—	0.73*	0.60*	0.54*	0.45*	0.44*	
4. Avoidance rec	0.24*	0.15*	0.63*	—	0.54*	0.48*	0.49*	0.45*	Clinic
5. Reasoning used	0.16*	0.16*	0.38*	0.40*	—	0.88*	0.55*	0.50*	15-19 yo, N = 298
6. Reasoning rec	0.19*	0.19*	0.40*	0.39*	0.89*	—	0.42*	0.36*	
7. Escalating used	0.58*	0.45*	0.23*	0.41*	0.48*	0.45*	—	0.88*	School
8. Escalating rec	0.46*	0.55*	0.23*	0.39*	0.43*	0.39*	0.85*	—	14-19 yo, N = 487
1. Physical used	—								
2. Physical rec	0.68*	—							
3. Avoidance used	0.27*	0.21*	—						
4. Avoidance rec	0.22*	0.16*	0.71*	—					
5. Reasoning used	0.30*	0.25*	0.52*	0.50*	—				
6. Reasoning rec	0.35*	0.22*	0.49*	0.49*	0.89*	—			
7. Escalating used	0.65*	0.54*	0.37*	0.35*	0.45*	0.45*	—		
8. Escalating rec	0.60*	0.61*	0.34*	0.35*	0.45*	0.39*	0.84*	—	
M	0.91	0.62	2.56	2.45	9.73	9.03	8.27	7.66	Clinic
SD	2.02	1.67	1.77	1.83	4.49	4.46	6.62	6.78	20-24 yo
M	1.15	0.76	2.48	2.49	9.72	9.18	8.64	8.19	Clinic
SD	2.08	1.85	1.68	1.72	3.96	4.10	6.26	6.61	15-19 yo
M	1.71	0.95	2.54	2.41	8.68	8.47	7.09	6.20	School
SD	2.70	2.14	1.69	1.66	4.15	4.18	5.57	5.52	14-19 yo

Note: Variables listed are additive frequency scales from the CADRI. Due to differing numbers of items per scale, these variables have different score ranges (avoidance, 0-6; reasoning, 0-30; escalating, 0-18; violence, 0-12). Rec = Received; yo = years old.

* $p < .05$.

clinic sample ($M = 17.78$) was slightly older than the adolescent school sample ($M = 16.02$). Ethnically, 40% of the adolescent clinic sample reported Latino descent, as compared to 76% of the adolescent school sample. Racially, 40% of the adolescent clinic sample reported their race as Black, 16% Asian American, and 12% White, as compared to the adolescent school sample who reported 48% Black, 1% Asian American, and 6% White. Despite demographic differences between these samples, the means for the communication variables suggest marginal differences (Table 1). Given evidence in the literature to the contrary (see Miller et al., 2010), it is surprising that violence means were lower, albeit only slightly, for both of the clinic samples. Though the correlations ($p < .05$) between the communication and physical violence variables for the most part were stronger within the adolescent school

Table 2. Means for Avoidance, Reasoning, and Escalation Strategies Among Women Using and Receiving Violence Compared to Those in Nonviolent Relationships

Sample	Strategies					
	Avoidance Used	Avoidance Received	Reasoning Used	Reasoning Received	Escalating Used	Escalating Received
Clinic, 20-24 yo						
No violence	2.21*	2.03*	8.96*	8.48*	5.78*	5.10*
Violence users	3.41	3.45	11.56	10.35	14.22	13.81
Violence receivers	3.36	3.56	11.61	10.20	14.81	15.00
Clinic, 15-19 yo						
No violence	2.23*	2.12*	9.09*	8.51*	5.95*	5.53*
Violence users	2.91	3.04	10.53	10.13	12.90	12.06
Violence receivers	2.78	3.17	10.78	10.22	13.96	13.99
School, 14-19 yo						
No violence	2.11*	2.06*	7.58*	7.17*	4.16*	3.56*
Violence users	3.14	2.81	10.15	10.02	10.64	9.17
Violence receivers	3.04	2.76	10.46	10.01	11.62	10.88

Note: Respondent groups defined by use and receipt of physical violence in dating relationship of past year. Due to differing numbers of items per scale, strategy types have differing score ranges (avoidance, 0-6; reasoning, 0-30; escalating, 0-18); *t* test difference *both* between the no-violence group and violence users *and* between the no-violence group and violence receivers. yo = years old.

**p* < .05.

sample—perhaps partially due to its higher violence means—the relative strength of the correlations between communication types was predominantly stable across samples. As predicted in our first hypothesis, in all samples, all communication strategies were used and received significantly more frequently (*t* test, *p* < .05) in violent relationships than nonviolent relationships (Table 2). In addition, for our second hypothesis we expected that adolescent females would report using more avoidant and escalating strategies than young adults. This was the case, if marginally, for escalating communication used, whereas adolescent clinic patients were actually less avoidant than young adult clinic patients. There were no significant differences between the adolescent and young adult clinic samples in mean frequencies of communication strategies and violence (*p* < .05).

Looking at the negative binomial regression models (*p* < .05) detailed in Tables 3 and 4, with the young adult clinic sample, interestingly, none of the control variables were predictive of the frequency of violence used or received. Regressions of the adolescent clinic sample revealed that greater frequency of physical violence used was associated with shorter relationships and reporting Black race, while greater frequency of received physical violence was associated with experiencing more pregnancies and receipt of child

Table 3. Comparison of Adolescent Women's Use of Physical Violence With Adolescent Women Not in a Physically Violent Relationship

Predictor	Dependent Variable: Physical Violence Used by Women					
	Clinic, yo 20-24 ^a		Clinic, 15-19 yo ^a		School, 14-19 yo	
	IRR	95% CI	IRR	95% CI	IRR	95% CI
Reasoning used	0.97	[0.89, 1.05]	0.96	[0.90, 1.03]	1.02	[0.97, 1.07]
Reasoning rec	0.97	[0.90, 1.04]	0.93*	[0.88, 0.99]	1.04	[1.00, 1.09]
Avoidance used	1.20*	[1.02, 1.42]	1.03	[0.90, 1.17]	1.08	[0.98, 1.19]
Avoidance rec	1.19*	[1.02, 1.39]	1.00	[0.88, 1.14]	0.98	[0.89, 1.07]
Escalating used	1.20*	[1.14, 1.26]	1.19*	[1.14, 1.24]	1.18*	[1.15, 1.22]
Escalating rec	1.18*	[1.14, 1.23]	1.13*	[1.09, 1.18]	1.15*	[1.11, 1.18]

Note: Negative binomial regressions conducted on violence users and respondents not in a violent relationship. Due to multicollinearity of used-received communication variable pairs, these pairs were divided into four models, presented here in one table for ease of interpretation. Control variables described in Methods section were included in all models. Variables listed are additive frequency CADRI scales. Rec = Received; IRR = incidence-rate ratios; CI = confidence interval; yo = years old.

a. Drawn from same larger sample of 15- to 24-year-old female clinic patients.

* $p < .05$.

sexual abuse. In the adolescent school sample, greater frequency of violence used was associated again with shorter relationships as well as with less important relationships and younger respondents, while greater frequency of violence received was associated with shorter relationships and experiencing child sexual abuse.

Regarding the key predictors in these multivariate models, escalating strategies were positively associated with physical violence used and received in all three samples, wherein a one-unit increase in the amount of escalating strategies by either partner was associated with an *increase* in violence used by 13% to 20% and violence received by 20% to 23%. The points of departure among these samples were with reasoning and avoidance. With this in mind, several age differences were apparent between the clinic samples. For the young adult clinic patients, avoidance used and received were associated with an *increase* in violence used (18%-20% per unit increase of avoidance), and reasoning used and received were associated with a *decrease* in violence received (9% per unit increase of reasoning). Conversely, for the adolescent patients, every unit increase of reasoning received was associated with a 7% *decrease* in violence used. This particular adolescent clinic sample result on

Table 4. Comparison of Adolescent Women’s Receipt of Physical Violence With Adolescent Women Not in a Physically Violent Relationship

Predictor	Dependent Variable: Physical Violence Received by Women					
	Clinic, yo 20-24 ^a		Clinic, 15-19 yo ^a		School, 14-19 yo	
	IRR	95% CI	IRR	95% CI	IRR	95% CI
Reasoning used	0.91*	[0.84, 0.98]	0.94	[0.87, 1.02]	0.99	[0.94, 1.05]
Reasoning rec	0.91*	[0.83, 0.99]	0.99	[0.92, 1.07]	0.99	[0.94, 1.04]
Avoidance used	1.06	[0.89, 1.27]	1.03	[0.89, 1.18]	1.08	[0.96, 1.21]
Avoidance rec	1.12	[0.93, 1.35]	0.95	[0.81, 1.11]	0.96	[0.85, 1.09]
Escalating used	1.21*	[1.14, 1.29]	1.21*	[1.15, 1.28]	1.22*	[1.18, 1.27]
Escalating rec	1.23*	[1.18, 1.29]	1.20*	[1.16, 1.25]	1.21*	[1.16, 1.25]

Note: Negative binomial regressions conducted on violence receivers and respondents not in a violent relationship. Due to multicollinearity of used-received communication variable pairs, these pairs were divided into four models, presented here in one table for ease of interpretation. Control variables described in Methods section were included in all models. Variables listed are additive frequency CADRI scales. Rec = Received; IRR = incidence-rate ratios; CI = confidence interval; yo = years old.

a. Drawn from same larger sample of 15- to 24-year-old female clinic patients.

**p* < .05.

reasoning—in only one sample and with a weak effect size—was the only to differentiate the two adolescent samples. Beyond this, the remaining results of the adolescent clinic sample were replicated with the adolescent school sample, with only escalating strategies (in all models) predicting violence.

In reviewing these results, it is apparent our third hypothesis held across multivariate analyses of all three samples for only reports of escalating strategies used and received, which were positively associated with violence used and received as expected. While we predicted for all samples that reasoning used and received would be negatively associated with violence used and received as in our previous article (Messinger et al., 2011), instead we found reasoning was negatively associated with violence only with the two clinic samples, and the gender of the violence user differed across the two age groups. Lastly, as with our previous article merging the young adult and adolescent clinic patients, we predicted for all samples that violence would not be associated with avoidance. However, the nonsignificant negative association in our previous article was significant in our present analyses on violence used by the young adult clinic patients.

Discussion

This study addressed an important gap in the IPV literature regarding the role of relationship communication among adolescents, an age group particularly

appropriate for early monitoring and intervention. Reflecting the literature, and as predicted in our first hypothesis, females in all three samples involved in violent relationships reported using and receiving all communication strategies—reasoning, avoidance, and escalating strategies—more frequently than those in nonviolent relationships. Future research could test whether this relationship is spurious with a conflict frequency measure since conflicts generate opportunities for both violence and conflict resolution communications. As to whether the literature is accurate in the posited time order for communication strategies, future research, especially longitudinal, will be invaluable. Given evidence of an increased IPV risk for clinic patients (see Miller et al., 2010), it was surprising that violence means would be lower within the clinic sample. Demographic sample differences could help explain this, but additional inquiry is needed. Importantly, contrary to what has been suggested and predicted in our second hypothesis, we found no significant differences between the adolescent and young adult clinic samples in reported mean frequencies of communication strategies and violence. This suggests that aging may affect the motivations behind and perceptions of communication strategies more so than the frequencies with which those strategies are employed.

In multivariate analysis, control variables provided both expected and unexpected results. That having experienced child sexual abuse is associated with violence receipt in the adolescent samples is consistent with prior research and suggests children can learn from parents to normalize violence victimization (e.g., Gómez, 2011; Heyman & Slep, 2002). However, the findings that shorter relationships in both adolescent samples and less important relationships in the adolescent school sample were associated with the use of violence runs contrary to prior adult and college student research on relationship seriousness (Lewis & Fremouw, 2001). Why no control variables were predictive of violence for the young adult clinic sample is not entirely clear.

Our third hypothesis regarding key variables in multivariate analysis was drawn only from prior research on young adults and adults due to the lack of similar research on adolescents, so in this regard these analyses were exploratory. It is perhaps not surprising that we found support for only a portion of our third hypothesis in that the reported use and receipt of escalating strategies were positively associated with the use and receipt of physical violence in all samples, a common result in research on adolescents (e.g., Halpern et al., 2001). Thus the key differences resided with reasoning and avoidance. When comparing the adolescent and young adult clinic patients, differences emerged that indicate our previous article (Messinger et al., 2011) may have masked age differences when combining these two groups in analysis. Our

results suggest that, once one reaches young adulthood, reasoning by either partner is not associated with violence by females but is predictive of a decrease in violence by their male partners. Future research should explore the qualitative use and interpretation of reasoning in relationships, with a strong focus on gender differences. As indicated by the two clinic samples, by young adulthood, temporary avoidance used and received may become a significant trigger to violence for women, which contradicts one of the few articles on this topic (Furman & Wehner, 1997). Significant correlates of avoidance did not differ across the two clinic samples, but it is possible that the perceptions and purposes of avoidance differ with age, such as avoiding to acquire control over a partner versus avoiding due to deficits in verbal reasoning. A conflict frequency variable in future research may help determine if these significant differences between age groups are in part explained by variance in differential mean conflict frequency, though this is less likely the case for escalating strategies given its large coefficient across samples.

This comparison of the young adult and adolescent clinic samples reaffirms our suspicion that existing studies on young adults are not a sufficient proxy for data on adolescents. By focusing analyses on our adolescent clinic sample and then comparing it to the adolescent school sample, we were able to explore replicability. Our two adolescent samples differed solely in that violence used by the females was negatively associated with reasoning received from their male partners only in the adolescent clinic sample. For the most part our findings provide evidence of generalizability with far more commonalities across population type (clinic vs. school and differing ethnic groups) than differences. While future research would do well to verify our results with additional adolescent populations, several intervention implications can be drawn from our adolescent results. With a one-unit decrease in escalating strategy frequency being associated with a 13% to 22% dip in violence frequency regardless of gender, finding ways to decrease the use of escalating strategies in adolescent relationships remains a potentially fruitful violence reduction strategy. Conversely, the inhibiting effect of reasoning on violence is present neither for males as reported by females in the adolescent *clinic* sample, nor for both males and females as reported by females in the adolescent *school* sample, which raises concerns as to the potential robustness of reasoning for defusing adolescent conflict. In addition, avoidance is not associated with violence in either adolescent model, indicating that this may not be a useful avenue for decreasing violence in adolescent relationships.

Like most research, this study is not without its limitations. In particular, for feasibility reasons, this study employs a cross-sectional design, so the

temporal relationship of strategies could not be tested. While relying on female self-reports from the male–female school sample enabled us to make stronger comparisons with the all-female clinic sample, it is possible that results and conclusions may have differed had males been included, particularly as evidence strongly suggests males tend to underreport physical violence in relationships relative to their female partners (Armstrong, Wernke, Medina, & Schafer, 2002). Furthermore, contextual variables like violence motivations, outcomes, and initiation were not assessed, so value labels like “abuser” and “victim” cannot be readily applied to our data (Williams, Ghandour & Kub, 2008). That said, these data push the discourse forward on communication in IPV relationships, both in verifying adolescent IPV relationship communication patterns across population types and suggesting potential points of departure between adolescents and young adults. Given these findings, future empirical and policy-oriented work should continue to explore whether indeed the use of a range of communication strategies is affected by life transitions between adolescence and young adulthood.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This report was supported in part by the cooperative agreement 5 U49 CE000731 from the Centers for Disease Control and Prevention (CDC) with the Center for Youth Violence Prevention at Columbia University. Its contents are the sole responsibility of the authors and do not necessarily represent the official views of the CDC or Columbia University.

References

- Armstrong, T. G., Wernke, J. Y., Medina, K. L., & Schafer, J. (2002). Do partners agree about the occurrence of intimate partner violence? A review of the current literature. *Trauma, violence & abuse, 3*, 181-193.
- Billingham, R. E., & Sack, A. R. (1986). Courtship violence and the interactive status of the relationship. *Journal of Adolescent Research, 1*, 315-325.
- Bird, G. W., Stith, S. M., & Schladale, J. (1991). Psychological resources, coping strategies, and negotiation styles as discriminators of violence in dating relationships. *Family Relations, 40*(1), 45-50.

- Cornelius, T. L., Shorey, R. C., & Beebe, S. M. (2010). Self-reported communication variables and dating violence: Using Gottman's marital communication conceptualization. *Journal of Family Violence, 25*, 439-448.
- Fernandez-Fuertes, A. A., & Fuertes, A. (2010). Physical and psychological aggression in dating relationships of Spanish adolescents: Motives and consequences. *Child Abuse & Neglect, 34*, 183-191.
- Fry, D. A., Davidson, L. L., Rickert, V. I., & Lessel, H. (2008). *Partners and peers: Sexual and dating violence among NYC youth* (A research report by the New York City Alliance Against Sexual Assault and the Columbia Center for Youth Violence Prevention, Columbia University). New York: New York City Alliance Against Sexual Assault.
- Furman, W., & Wehner, E. (1997). Adolescent romantic relationships: A developmental perspective. In S. Shulman & W. A. Collins (Eds.), *Romantic relationships in adolescence: Developmental perspectives. New directions for child development, No. 78* (pp. 21-36). San Francisco, CA: Jossey-Bass.
- Gómez, A. M. (2011). Testing the cycle of violence hypothesis: Child abuse and adolescent dating violence as predictors of intimate partner violence in young adulthood. *Youth and Society, 43*, 171-192.
- Gryl, F. E., Stith, S. M., & Bird, G. W. (1991). Close dating relationships among college students: Differences by use of violence and by gender. *Journal of Social and Personal Relationships, 8*, 243-264.
- Halpern, C. T., Oslak, S. G., Young, M. L., Martin, S. L., & Kupper, L. L. (2001). Partner violence among adolescents in opposite-sex romantic relationships: Findings from the National Longitudinal Study of Adolescent Health. *American Journal of Public Health, 91*(10), 1679-1685.
- Heyman, R. G., & Slep, A. M. S. (2002). Do child abuse and interparental violence lead to adulthood family violence? *Journal of Marriage and the Family, 64*, 864-870.
- Josephson, W. L., & Proulx, J. B. (2008). Violence in young adolescents' relationships: A path model. *Journal of Interpersonal Violence, 23*, 189-208.
- Laursen, B., & Collins, W. A. (1994). Interpersonal conflict during adolescence. *Psychological Bulletin, 115*, 197-209.
- Lewis, S. F., & Fremouw, W. (2001). Dating violence: A critical review of the literature. *Clinical Psychology Review, 21*(1), 105-127.
- Lloyd, S. A. (1990). Conflict types and strategies in violent marriages. *Journal of Family Violence, 5*, 269-283.
- Messinger, A. M., Davidson, L. L., & Rickert, V. I. (2011). IPV among adolescent reproductive health clinic patients: The role of relationship communication. *Journal of Interpersonal Violence, 26*, 1851-1867.

- Miller, E., Decker, M. R., Raj, A., Reed, E., Marable, D., & Silverman, J. G. (2010). Intimate partner violence and health care-seeking patterns among female users of urban adolescent clinics. *Maternal Child Health Journal, 14*, 910-917.
- Morse, B. J. (1995). Beyond the conflict tactics scale: Assessing gender differences in partner violence. *Violence and Victims, 10*(4), 251-272.
- O'Leary, K. D. (1999). Developmental and affective issues in assessing and treating partner aggression. *Clinical Psychology: Science and Practice, 6*, 400-414.
- O'Leary, K. D., Smith Slep, A. M., Avery-Leaf, S., & Cascardi, M. (2008). Gender differences in dating aggression among multiethnic high school students. *Journal of Adolescent Health, 42*, 473-479.
- Rennison, C. M. (2001). *Special report: Intimate partner violence and age of victim, 1993-99* (NCJ No. 187635). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Ridley, C. A., & Feldman, C. M. (2003). Female domestic violence toward male partners: Exploring conflict responses and outcomes. *Journal of Family Violence, 18*, 157-170.
- Rivara, F. P., Anderson, M. L., Fishman, P., Reid, R. J., Bonomi, A. E., Carrell, D., & Thompson, R. S. (2009). Age, period, and cohort effects on intimate partner violence. *Violence and Victims, 24*, 627-638.
- Royston, P. (2009). Multiple imputation of missing values: Further update of ice, with an emphasis on categorical variables. *Stata Journal, 9*, 466-477.
- Sabourin, T. C. (1996). The role of communication in verbal abuse between spouses. In Cahn, D. D., & Lloyd, S. A. (Eds.), *Family violence from a communication perspective* (pp. 199-217). Thousand Oaks, CA: SAGE.
- Stets, J. E., & Straus, M. A. (1990). The marriage license as hitting license: A comparison of assaults in dating, cohabiting, and married couples. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 227-244). New Brunswick, NJ: Transaction.
- Williams, J. R., Ghandour, R. M., & Kub, J. E. (2008). Female perpetration of violence in heterosexual intimate relationships: Adolescence through adulthood. *Trauma, Violence, & Abuse, 9*(4), 227-249.
- Wolfe, D. A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A. L. (2001). Development and validation of the Conflict in Adolescent Dating Relationships Inventory. *Psychological Assessment, 13*, 277-293.

Bios

Adam M. Messinger, PhD, is an Assistant Professor of Justice Studies at Northeastern Illinois University. He is also continuing his research collaboration spanning the past several years with the Centers for Disease Control and Prevention's

ACE (National Academic Centers for Excellence in Youth Violence Prevention) at Columbia University. His research focuses on youth violence prevention - particularly regarding intimate partner violence, child abuse, sexual violence, and youth bullying - and its intersections with gender identity, sexual orientation, stigma, and the criminal justice system.

Vaughn I. Rickert, PsyD, is a professor of pediatrics and director of the Section of Adolescent Medicine at Indiana University School of Medicine and Riley Hospital for Children. He received his doctorate in Clinical Psychology from Central Michigan University. His research interests focus on adolescent relationship violence and contraceptive use in this population. Finally, Dr. Rickert is a past president of the Society for Adolescent Medicine or SAM, a multidisciplinary professional society devoted exclusively to the health and well-being of adolescents.

Deborah A. Fry, MA, MPH, is a research fellow at Centre for Learning in Child Protection at the University of Edinburgh. Her primary research interests are in the areas of child sexual abuse, sexual violence, children who display sexually harmful behavior, and intimate partner violence prevention and response. Prior to joining the Centre, Deborah was the Research Director at the NYC Alliance Against Sexual Assault.

Harriet Lessel, CSW, is founder and former Executive Director of The New York City Alliance Against Sexual Assault. Prior to this position, Ms. Lessel spent ten years managing the rape crisis and domestic violence program at the Long Island College Hospital (LICH) in Brooklyn, New York. In addition, she developed the first Sexual Assault Examiners program in Brooklyn, which helps improve the hospital care of rape survivors. She has been active in city and state-wide anti-sexual violence and crime victims coalitions, and, as a certified social worker, previously she was a counselor and advocate for survivors of sexual assault and abuse.

Leslie L. Davidson, MD, is a pediatrician and epidemiologist. Her primary research interests are screening, and epidemiology focusing on the prevention of accidents and violence, particularly intimate partner violence. She has also conducted substantial research in disability in children and in international child health. She is a professor of clinical epidemiology and clinical pediatrics at the Mailman School of Public Health at Columbia University and associate director of the Columbia Center for Youth Violence.

Publication 4

Fry, D. Messinger, A.M., Rickert, V.I., O'Connor, M.K., Palmetto, N., Lessel, H., and Davidson, L.L. (2014) Adolescent Relationship Violence: Help-Seeking and Help-Giving Behaviors among Peers. *Journal of Urban Health*, 91(2): 320-334.

Copyright permission obtained from Springer Publications and the co-authors of this publication to use and archive this journal article within this PhD by Publications thesis.

Adolescent Relationship Violence: Help-Seeking and Help-Giving Behaviors among Peers

Deborah A. Fry, Adam M. Messinger, Vaughn I. Rickert,
Meghan K. O'Connor, Niki Palmetto, Harriet Lessel, and
Leslie L. Davidson

ABSTRACT *Young people tend to disclose relationship violence experiences to their peers, if they disclose at all, yet little is known about the nature and frequency of adolescent help-seeking and help-giving behaviors. Conducted within a sample of 1,312 young people from four New York City high schools, this is the first paper to ask adolescent help-givers about the various forms of help they provide and among the first to examine how ethnicity and nativity impact help-seeking behaviors. Relationship violence victims who had ever disclosed (61 %) were more likely to choose their friends for informal support. Ethnicity was predictive of adolescent disclosure outlets, whereas gender and nativity were not. Latinos were significantly less likely than non-Latinos to ever disclose to only friends, as compared to disclosing to at least one adult. The likelihood of a young person giving help to their friend in a violent relationship is associated with gender, ethnicity, and nativity, with males being significantly less likely than females to give all forms of help to their friends (talking to their friends about the violence, suggesting options, and taking action). Foreign-born adolescents are less likely to talk or suggest options to friends in violent relationships. This study also found that Latinos were significantly more likely than non-Latinos to report taking action with or on behalf of a friend in a violent relationship. This research shows that adolescents often rely on each other to address relationship violence, underlining the importance of adolescents' receipt of training and education on how to support their friends, including when to seek help from more formal services. To further understand the valuable role played by adolescent peers of victims, future research should explore both which forms of help are perceived by the victim to be most helpful and which are associated with more positive outcomes.*

KEYWORDS *Dating violence, Relationship violence, Help-giving, Help-seeking, Adolescents, Peer support*

Adolescent relationship violence—sexual, physical, or psychological abuse between adolescent romantic partners—is prevalent^{1,2} with estimates suggesting that approximately one in 10 adolescents are victims of relationship violence.^{3,4} The health consequences of adolescent relationship violence are varied and can include increased

Fry is with the University of Edinburgh/NSPCC Child Protection Research Centre, Edinburgh, UK; Messinger is with the Justice Studies Department at Northeastern Illinois University, Chicago, IL, USA; Rickert is with the Indiana University School of Medicine, Indianapolis, IN, USA; O'Connor is with the International Womens' Program at the Open Society Institute, New York, NY, USA; Palmetto is with the Epidemiology division at Pfizer Inc., New York, NY, USA; Lessel is with the NYC Alliance Against Sexual Assault, New York, NY, USA; Davidson is with the Center for Youth Violence Prevention at the Mailman School of Public Health at Columbia University, New York, NY, USA.

Correspondence: Deborah A. Fry, University of Edinburgh/NSPCC Child Protection Research Centre, Edinburgh, UK. (E-mail: Debi.Fry@ed.ac.uk)

risk of eating disorders, suicidal thoughts or attempts, low self-esteem and poor emotional well-being, substance abuse, risky sexual behaviors, teen pregnancy, and STIs.⁵⁻¹³

While relationship violence poses serious challenges for victims, it may also affect peers because these friends of victims may play an important supportive role. Often such peers do not have the knowledge or skills to handle these situations. To date, little research has explored which adolescents are most likely to seek help from peers, and no study has detailed the range of supports peers report employing to help their friends. The present paper begins to fill these important gaps in the literature by examining in four New York City (NYC) high schools, both the self-reported help-seeking behaviors of adolescent relationship violence victims as well as the range of help-giving behaviors utilized by peers to whom victims disclose. Results will inform the development of interventions designed to assist young people in more effectively responding to relationship violence victimization disclosure by a friend.

ADOLESCENT HELP-SEEKING BEHAVIORS

Less than half of adolescent victims of relationship violence ever seek help from anyone¹⁴ and those that do predominantly disclose to *informal support sources* like their friends and family rather than *formal support sources* like health professionals and law enforcement.¹⁴⁻¹⁶ Receiving help from informal social supports may have positive effects for victims, including lower levels of depression and anxiety,¹⁷ elevated confidence and openness to future help-seeking,¹⁸ and for those experiencing less violent relationships, a lower risk of being re-abused than traditionally found among relationship violence victims.¹⁹

When adolescent victims disclose to informal support sources, they initially disclose solely to peers in nearly three out of four cases,²⁰ particularly when the victim's relationship entails less physical violence.²¹ In fact, as many as 54 % of high school students indicate that they personally know a relationship violence victim.²³ Adolescents also turn to peers for support in the case of sexual violence victimization, whether the victimization occurred in or outside of a relationship. According to an analysis of the *National Survey of Adolescents*, adolescent women whose unwanted sexual experience occurred while they were high school age more often told a peer than told others about the incident.²⁴

This pattern of victims turning to peers for support may in part be due to a perception that peers are less likely than adults to breach confidentiality or blame the victim.^{24,25} Additionally, adolescents often talk to other adolescents more freely than to adults about their personal lives and romantic relationship problems. Such conversations in turn can lead to victimization disclosures.¹⁶ Adolescents are only more likely to reach out to adults than peers when physical violence is severe and escalating, perhaps because adults may be perceived as having more power to intervene.²¹

Unfortunately, the majority of adolescent victims tell no one about the violence they are experiencing in their relationships. Research consistently finds that males are less likely to seek help than females.²¹ It has been speculated that this may be due in part to certain masculinity norms that inhibit help-seeking and reporting victimization in general.²² The dearth of victim services designed for men may also serve as a deterrent from seeking formal help. Considerably less attention has been paid by scholars to race-ethnicity and nativity in help-seeking behaviors among adolescents, although an emerging literature suggests that social minority status and cultural norms can inhibit disclosure and help-seeking.²⁶

ADOLESCENT HELP-GIVING BEHAVIORS

There are three main forms of help identified by the literature that adolescent peers and adults may provide to victims: emotional support (e.g., sympathy, encouragement), advice, and engaging in tasks that help the victim cope with or escape from relationship violence.¹⁴ Adults appear to employ all three forms of help with some regularity. According to a large national study, 88 % of adults provided emotional support to victims, approximately half directed victims to a professional agency like the police or shelters, and one in six took action on behalf of the victim either by offering financial support, providing a place for the victim to stay, or helping the victim leave the relationship.²⁷ Preliminary evidence based on responses to hypothetical scenarios suggests that adolescents differ from adults in that adolescents may predominantly provide emotional support,^{15,28} with friends often being viewed by victims as resources through which to “sort things out” and feel emotionally supported.²⁹ This possible reliance on emotional support from peers with less emphasis on providing advice and taking action may be explained by their youth and lack of experience, whereby they may be less aware of the options available. They also have few instrumental and financial resources available to them. Much of what has been studied about adolescent help-giving behavior is based on responses to hypothetical scenarios rather than their own experiences.^{15,28} The sole study to explore help-giving responses to actual adolescent victim disclosures assessed emotional support and relied upon victims to report on the help-giving behaviors they received rather than sampling the help-givers directly.¹⁶ Research is needed that directly surveys adolescent help-givers about the forms of help they provide.

Given the nascent state of this literature, it is not surprising that research has yet to investigate whether types of help-giving behaviors vary across demographic groups. Additionally, in light of evidence suggesting that minority status and cultural norms can serve to inhibit racial and ethnic minorities and immigrants from seeking out informal help-giving sources²⁶ and since friendships tend to be between members of the same demographic group,³⁰ many friends of minority and immigrant victims in violent relationships are likely to be minorities and immigrants themselves. Thus, it is possible that many of the same cultural, language, and stigma-related barriers that deter minority and immigrant victims from seeking help may also hinder peers from these demographic groups from providing their friends with a wide array of support options. Lastly, it is well-known that there are significant barriers to help-seeking for sexual assault survivors and that those who do decide to seek help face both positive and negative responses,^{31,32,42} no work to date has been conducted on whether a history of child sexual abuse or relationship violence is associated with the likelihood of providing support and help to a peer who discloses relationship violence.

The present paper represents the first effort in the adolescent relationship violence literature to explore help-giving behaviors as reported by the help-givers, including establishing the prevalence of and factors which predict a broad range of help-giving behaviors. It is also among the first to examine how ethnicity and nativity impact help-seeking behaviors.

METHODS

Study Design

This study was conducted in four NYC high schools during the 2006–2007 school year. To identify schools, initial outreach was conducted using convenience sampling. Fifteen potential high schools across the five boroughs of NYC were identified for potential inclusion. Eleven high schools were unable to participate due

to the study timing and existing workloads. Four schools expressed interest in participating and were chosen for this study. Three schools were widely distributed in Manhattan, and one school was located in Brooklyn. One of the schools was located within a predominately Latino community. In addition, one school was classified as an alternative transfer high school, meaning students must be at least 16 years old and have attended another high school prior to enrolling. The transfer high school provides students the opportunity to earn their high school diploma in a smaller, student-centered learning community.²⁰ Our study sample follows the same age distribution patterns as NYC Department of Education data for all students in NYC over the same time period.²⁰ Owing to multi-organizational involvement, the protocol and consent for this study were reviewed and approved by three Institutional Review Boards including that of the NYC Department of Education and permission was also received from each of the corresponding School Board Superintendents and School Principals. Passive parental consent was obtained after mailing letters to the parents in English, Spanish, and/or Chinese which contained study information and the opportunity to refuse consent through return of a form in a self-addressed and stamped envelope. Students whose parents refused consent were not invited to participate in the study. Active assent of the student was also requested at the time of survey implementation.

Due to the prevalence of relationship violence among adolescents and the sensitive nature of the survey questions, the study partners felt it was imperative to provide students with referral information for local counseling services. In planning the study, the authors conducted focus groups with young people to develop a youth-friendly referral leaflet specifically for the study. Through this process, the *NYC Teen Health Map* was developed to provide sexual and relationship violence referral information in a discrete way. The pocket-size foldable maps include a youth-designed cover with a NYC subway map on one side and specific youth referral information for relationship violence and non-partner sexual violence on the other side in small print. In addition to developing the referral maps, the study partners also engaged with young people who acted as evaluators of the services listed to ensure that they were appropriate and responsive to young people. Maps and a brochure about healthy relationships were given to each student in the four participating schools, regardless of study participation. During data collection, trained rape crisis advocates were also available in case a student wanted to talk to someone or receive further information. Several members of the research team were also certified crisis counselors. No student approached the team to discuss any issues that arose as a result of the study, but several of the young people asked for more NYC Teen Health Maps to give to their friends in other schools. Study results were shared with faculty, students, and parents in each school.

Surveys were implemented during the school week in health and physical education classes. Students were offered a \$10 gift card to a bookstore for participating (for more detailed methods, see²⁰). Two of the four schools completed an audio computer assisted or ACASI version of the survey, and owing to a lack of computer availability, the other two schools utilized a paper and pencil version. The two school samples using the paper surveys rather than ACASI had significantly greater proportions of females, non-Latinos, and native-born students, but the survey format was not associated with any of the dependent variables of interest regarding help-seeking and help-giving behaviors ($\chi^2, p < 0.05$).

Students chose whether they wished to take the survey in English or in Spanish. The participation rate for the study was 70 %. Forty-six parents opted their child

out of the study, and 52 youths opted themselves out. Of the 1,454 students who participated and answered at least one survey question, 142 were removed from analysis for extensive missing data.

Survey Measures

Help-Seeking. Help-seeking behavior was assessed through the questions to those reporting the experience of relationship violence, “Did you ever tell anyone about experiencing any physical and sexual violence from a partner,” “Who did you tell first,” and “Who else did you tell?” The response categories for disclosure included parent, doctor or health professional, friend, minister, priest or rabbi, therapist or counselor, and other. Three variables were constructed out of these items for analyses. First, a dichotomous variable assessed whether or not disclosure occurred. Second, among those who had disclosed to someone, a binary variable assessed who was disclosed to first, a friend or an adult. A third variable was constructed that indicated, among those who ever disclosed violence, did they tell only friends or at least one adult. Due to a Spanish translation omitting a word in one question, Spanish language surveys were excluded for help-seeking behavior variables ($n=77$). The help-seeking analyses were conducted among adolescents who reported ever experiencing physical or sexual violence within their relationship and who answered the help-seeking questions ($n=126$).

Help-Giving. Help-giving behavior was assessed if the adolescent reported that they had a friend in a violent relationship. For all who responded affirmatively, each completed nine follow-up questions about the nature of any support they may have provided across three non-overlapping help-giving domains: talking to their friend, suggesting options, and taking action. Talking to their friend was assessed through the item, “Have you talked to this friend about the violence?” Suggesting options to their friend was assessed through four items asking, “Have you given this friend advice?,” “Have you told him/her to call a hotline?,” “Have you told him/her to talk to an adult?,” and “Have you told him/her to leave this partner?” Taking action on behalf of or with the victim was assessed through four items asking, “Have you called a hotline to figure out how to help your friend?,” “Have you gone with your friend to get some help like at a clinic?,” “Have you talked to the partner directly about his/her violence?,” and “Have you talked to an adult about your friend’s problem?” Cronbach’s alphas were modest for both the suggesting options ($\alpha=0.53$) and taking action scales ($\alpha=0.51$), suggesting that respondents relied upon a broad range of tactics within these two help-giving categories. The help-giving analyses were conducted with adolescents who reported having a friend in a violent relationship ($n=272$).

Relationship Violence Victimization. A history of lifetime physical and sexual relationship victimization was measured using the 23-item Dating Violence Inventory and Family Abuse Scale developed by Symons and colleagues.³³ Respondents were asked how often in their lives (ranging from “never” to “4 or more times”) a current or previous partner had used physical relationship violence against them (e.g., “Slapped or hit you,” “Punched you,” “Choked you”) and sexual relationship violence against them (e.g., “Tried to force you into sexual activity,” “Raped you”). For the purposes of analysis, a dichotomous variable was constructed in which respondents were categorized as either having experienced at least one incident of relationship violence victimization (coded 1) or not (coded 0).

Child Sexual Abuse Victimization. Child sexual abuse was measured using a series of questions expanded from those proposed by Symons et al.³³ These questions were preceded in the survey by a definition of sexual abuse: “when we ask about ‘sexual abuse,’ we mean any sexual fondling, touching, oral sex or intercourse (penetration of the vagina or anus with a penis, fingers or object).” Respondents were then asked in five separate items, “How often in your life has...your parent sexually abused you or forced you to have sex...a family member other than a parent sexually abused you or forced you to have sex...an older acquaintance (such as a family friend, teacher, minister, neighbor, etc.) sexually abused you or forced you to have sex...someone else your age who you knew but was not your partner sexually abused you or forced you to have sex....and a stranger sexually abused you or forced you to have sex?” Response categories ranged from “never” to “4 or more times.” In analyses, child sexual abuse was coded as a dichotomous variable, where respondents were categorized as either having experienced at least one child sexual abuse incident or not.

Demographic Variables. The demographic variables analyzed in this study include gender, ethnicity, and nativity. Ethnicity was measured with two questions, “Are you of Latino descent or background?” (yes or no) and “Which racial group(s) do you identify with or belong to?” (Black, White, Asian, another racial group). Nativity was assessed through the question, “Were you born in the U.S.?” (yes or no).

Missing Data

Of the full sample of 1,312 respondents, minimal data were missing on gender (missing $n=1$), Latino ethnicity ($n=2$), national origin ($n=7$), age ($n=6$), history of child sexual abuse ($n=41$), help-seeking variables ($n=40$), and whether the respondent ever had a friend in a violent relationship ($n=58$). Of those who reported having a friend in a violent relationship, few respondents did not complete the help-giving items on talking to their friend ($n=6$), suggesting options ($n=10$), and taking action ($n=9$). Of the 1,015 respondents who answered in the affirmative to a screening question regarding whether they had ever had a romantic or sexual relationship, only two respondents did not complete all of the survey items on lifetime physical and sexual relationship violence victimization history. Of the variables with the greatest missing data—child sexual abuse, help-seeking, and having a friend disclose relationship violence—two thirds of respondents had missing data on only one of these variables. Males were significantly less likely than females to answer the help-seeking items and the item regarding whether a friend had disclosed relationship violence. Given that little data were missing, listwise deletion of missing cases was used for analyses.

Data Analyses

Univariate analyses were performed on all variables, including demographic variables, relationship and sexual violence victimization histories, help-seeking behaviors, and help-giving behaviors. Bivariate logistic regression analyses were employed to examine help-seeking behaviors to determine if the odds of disclosing to anyone by the time of the survey were associated with gender, Latino ethnicity, and nativity and to determine if the odds of who was disclosed to first, a friend or an adult, are associated with gender, Latino ethnicity, and nativity. Finally, for help-seeking behaviors, bivariate logistic regression was used to determine if gender,

Latino ethnicity, and nativity were associated with the odds of ever only disclosing to friends by the time of the survey, relative to ever disclosing to any adult.

For help-giving behaviors, bivariate logistic regression analyses were employed to determine whether the help-giver's history of child sexual abuse or dating violence victimization was associated with talking with their friend, suggesting options, and taking action with or on behalf of their friend in a violent relationship. Lastly, multiple variable logistic regression explored whether gender, Latino ethnicity, and nativity were associated with talking with their friend, suggesting options, and taking action with or on behalf of their friend in a violent relationship. Since the help-giver's personal experiences of child sexual abuse and dating violence victimization were not significant predictors of help-giving behaviors in the bivariate analyses, they were not included in the multiple variable regression model in the interest of model parsimony and statistical power. Unlike the multiple variable regression analysis, all other previously mentioned non-univariate analyses were conducted in a bivariate rather than multiple variable regression format due to their smaller model sample sizes.

RESULTS

Sample Description

The demographic characteristics of the sample are reported in Table 1. As can be seen, slightly more than half were female, and about half were between the ages of 15 and 16. Almost three quarters of the sample reported Latino ethnicity, while self-reported race varied widely. Finally, about one quarter were born outside of the USA.

With regard to victimization, 38 % ($n=384$) of respondents reported experiencing physical and/or sexual relationship violence at some point in their lifetime, with 36 % ($n=363$) reporting physical relationship violence victimization and 10 % ($n=98$) sexual relationship violence victimization. Of all respondents, 6 % ($n=81$) reported one or more occurrences of experiencing child sexual abuse in their lifetime.

Help-Seeking Behaviors

Of youth who had experienced relationship violence (physical and/or sexual) and answered the help-seeking questions, 61 % ($n=78$) told someone about that violence by the time of the survey. According to bivariate logistic regression models predicting the help-seeking variables, among those who experienced relationship violence in their lifetime, male victims were significantly less likely than female victims to seek help (odds ratio (OR)=0.27, 95 % confidence interval (CI) 0.13–0.60). However, there were no significant differences in help-seeking behavior by ethnicity or nativity for adolescents who had experienced relationship violence.

Gender and nativity were not associated with the type of people ever disclosed to for relationship violence. Relationship violence victims who had disclosed were more likely to choose their friends for informal support. Of those that disclosed their experiences of relationship violence victimization, a small percentage (12 %, $n=9$) had only told an adult about the violence, nearly half (46 %, $n=36$) had only ever told a friend but no adult, and 42 % ($n=33$) had told both an adult and a friend. Additionally, the first person initially disclosed to was a friend for 72 % of relationship violence victims.²⁰ Turning to the bivariate logistic regression results in Table 2, Latinos were found to be significantly less likely to ever disclose only to friends, as compared to ever disclosing to at least one adult. Table 3 highlights that Latinos had significantly lower odds than non-

TABLE 1 Demographic characteristics of sample (*n*=1,312)

Variable	<i>n</i> (%)
Age	
14 or younger	239 (18)
15 to 16	628 (48)
17 and older	439 (34)
Gender	
Female	737 (56)
Male	574 (44)
Ethnicity	
Latino	962 (73)
Non-Latino	348 (27)
Race	
Black	557 (48)
White	87 (7)
Asian American	47 (4)
Other	370 (32)
Mixed	109 (9)
Nativity	
Born in the USA	1,001 (77)
Born in another country	304 (23)

Latinos of telling a friend first (as opposed to an adult) about their relationship violence victimization.

Help-Giving Behaviors

Over a fifth (22 %) of the students reported that they had a friend currently in a violent relationship (*n*=272). Of these students, 69 % identified as female, 66 % identified as Latino, and 81 % were born in the USA.

TABLE 2 Bivariate logistic regression analysis of help-seeker characteristics predicting help-seeking behaviors among respondents who reported ever disclosing relationship violence (*n*=78)

Predictor	Disclosed to adults(s) ^a		Only disclosed to friend(s)	
	<i>n</i> =42		<i>n</i> =36	
	<i>n</i> (%)		<i>n</i> (%)	OR 95 % CI
Gender				
Male	8 (19)		10 (28)	1.67 0.54, 5.15
Female	34 (81)		26 (72)	
Ethnicity				
Latino	35 (83)		21 (58)	0.28* 0.10, 0.81
Other	7 (17)		15 (42)	
Nativity				
Foreign Born	32 (76)		29 (81)	0.68 0.21, 2.16
US Born	10 (24)		7 (19)	

OR odds ratio

**p*<0.05

^aIncludes respondents who ever disclosed to only adults or ever disclosed to friends and adults

TABLE 3 Bivariate logistic regression analysis of help-seeker characteristics predicting who was disclosed to first (*n* = 78)

Predictors	Y: initial disclosure outlet			
	Disclosed to adult first (reference group; <i>n</i> = 22)		Disclosed to friend first (<i>n</i> = 56)	
	<i>n</i> (%)		<i>n</i> (%)	
Gender				
Male	5 (23)		13 (23)	1.02
Female	17 (77)		43 (77)	0.32, 3.32
Ethnicity				
Latino	20 (91)		36 (64)	0.18**
Other	2 (.09)		20 (36)	0.04, 0.850
Nativity				
Foreign born	16 (73)		45 (80)	0.65
US born	6 (27)		11 (20)	0.21, 2.05

Each bivariate analysis included one predictor and the dependent variable, although all predictors are presented here for ease of comparison

OR odds ratio

***p* < 0.01

Adolescents responded to their friends' situation in a variety of ways (Table 4). Some of the more common approaches included talking with the friend about the violence (79 %), giving advice (82 %), telling the friend to leave the partner (80 %), talking directly to the friend's partner about the violence (52 %), telling the friend to talk to an adult about the violence (50 %), and talking to an adult about the friend's experience of violence (47 %). Among the least commonly employed tactics were calling a hotline on behalf of the friend (14 %) and advising the friend to call a hotline (19 %).

Figure 1 illustrates the relationship between the types of help given by adolescents to their friends. From this diagram, we can see that very few adolescents gave only one form of help to their friends who were in a violent relationship, with the majority of adolescents (64 %) providing all three types of help—talking to their friends, suggesting options to their friends, and taking action on behalf of or with their friends.

As can be seen in the bivariate logistic regressions (Table 5), help-givers' histories of

TABLE 4 Frequencies of help-giving behaviors

Type of help given	<i>n</i> (%)
Talked with friend	209 (79.2)
Offered suggestions	242 (91.3)
Gave friend advice	216 (81.5)
Told friend to call hotline	49 (18.6)
Told friend to talk to adult	134 (50.4)
Told friend to leave partner	209 (80.1)
Took action	201 (76.0)
Talked with friend's partner directly	137 (51.9)
Called a hotline	36 (13.5)
Talked to an adult about friend	124 (46.6)
Went with friend to get services	83 (31.4)

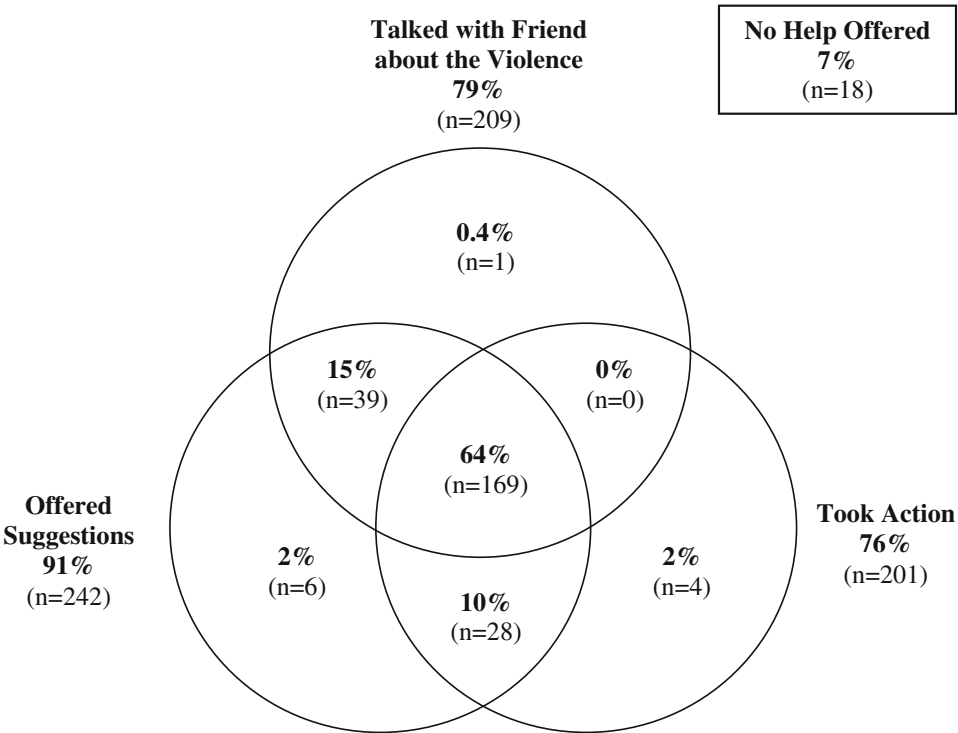


FIGURE 1. Venn diagram of types of help given to friends experiencing relationship violence. Subsample analyzed includes respondents who provided help to a peer for IPV victimization and who had complete data on all three help-giving scales (*n* = 265)

relationship violence victimization and child sexual abuse victimization were not significantly associated with any type of help-giving behavior. However, we did find that males were less likely than females to give all forms of help to their friends. The only

TABLE 5 Analysis of which help-giver characteristics predicted help-giving behaviors: bivariate logistic regressions

Predictors	Y1: talk with friend		Y2: suggest options		Y3: take action	
	OR	95 % CI	OR	95 % CI	OR	95 % CI
Gender						
Male	0.37**	0.20, 0.69	0.24*	0.09, 0.58	0.38**	0.21, 0.69
Ethnicity						
Latino	0.91	0.48, 1.70	1.56	0.65, 3.71	2.22*	1.25, 3.95
Nativity						
Foreign born	0.38*	0.19, 0.74	0.32*	0.13, 0.79	1.20	0.57, 2.50
History of relationship violence	1.04	0.54, 2.00	0.56	0.20, 1.57	1.04	0.56, 1.93
History of child sexual abuse	0.59	0.24, 1.44	— ^a		0.75	0.31, 1.81

Each bivariate analysis included one predictor and the dependent variable, although all predictors are presented here for ease of comparison

OR odds ratio

p* < 0.05; *p* < 0.01

^aSub-sample size too small to draw statistical conclusions

significant difference in help-giving behaviors by ethnicity was that Latinos were more likely than non-Latinos to take action. Foreign-born adolescents had significantly lower odds than US-born young people of talking to their friends about the violence as well as suggesting options for their friends, while there was no significant difference between the two groups with regards to taking action to help their friends.

Table 6 displays the adjusted odds of help-giving to friends experiencing relationship violence. We found that after controlling for ethnicity and nativity, males were significantly less likely to give all forms of help to their friends. Foreign-born adolescents were significantly less likely to talk to their friends and suggest options to their friends, but there was no significant difference regarding taking action on behalf of, or together with, friends experiencing relationship violence. After adjusting for gender and nativity, Latinos were nearly twice as likely as non-Latinos (OR (95 % CI)= 1.91 (1.06, 3.46)) to take action to help to their friends, but no significant differences were found between these two groups regarding the other help-giving behaviors.

DISCUSSION

Adolescents are in a unique position to provide support to peers involved in relationship violence. Over a fifth of all respondents reported currently having a friend in a violent relationship. Moreover, our research shows that the majority of relationship violence victims (72 %) who disclose their experiences with relationship violence disclose to their friends *first*, with approximately nine in ten victims ever disclosing to peers by the time of the survey.

One promising finding from our research is that adolescent help-givers of their peers who were victims of relationship violence readily provide all three forms of assistance that were asked about in the survey, including taking action (accounting for 76 % of respondents who knew a relationship violence victim), talking with their friend about the violence (79 %), and, most commonly, offering suggestions (91 %). Two thirds of help-givers gave all three types of support. At the same time, the specific tactics taken within these three help-giving strategies leaned toward helping the victim escape the abuser without the assistance of professionals who may be particularly valuable in maintaining the safety of escaping victims. Among the more commonly given suggestions, 80 % of adolescents told their friend to leave the abuser. While revealing

TABLE 6 Analysis of which help-giver characteristics predicted help-giving behaviors: multiple variable logistic regressions

Predictors	Y1: talk with friend		Y2: suggest options		Y3: take action	
	OR	95 % CI	OR	95 % CI	OR	95 % CI
Gender						
Male	0.38*	0.20, 0.71	0.25*	0.10, 0.63	0.41*	0.23, 0.75
Ethnicity						
Latino	0.79	0.40, 1.53	1.30	0.52, 3.23	1.91*	1.06, 3.46
Nativity						
Foreign born	0.39*	0.19, 0.78	0.32*	0.13, 0.81	1.26	0.59, 2.69

All three models adjusted for gender, ethnicity, and nativity
OR odds ratio
**p*<0.05

empathy by the peer supporter and having the potential for positive outcomes, without accompanying expert-provided advice and assistance, an escaping victim may be at risk of retribution by the abuser.³⁴ Likewise, the most common action taken (for 52 % of help-givers) was talking directly with the friend's abuser, which similarly has the potential to pose safety risks to the victim and the help-giver.³⁴ By comparison, only 19 % recommended that the victims reach out to professional help through a hotline, and only 14 % of help-givers called a hotline on behalf of their friend. While hotline expertise was not typically sought out, the assistance of adults often was, with 50 % suggesting to the victim that he or she should talk to an adult and 47 % talking to an adult on behalf of the victim. Ultimately, the finding that adolescents are highly likely to respond to the needs of their victimized peers suggests that programs designed to better support and educate adolescents about help-giving may have positive and far-reaching implications for adolescent victims of relationship violence.

As for difference between demographic groups, ethnicity was predictive of whom adolescents disclosed to, whereas gender and nativity were not. Latinos were significantly less likely than non-Latinos to ever disclose only to friends, as compared to disclosing to at least one adult. In line with the empirical literature and theories of masculinities performance, males were less likely to ever seek help.²² There was no association between foreign birth and help seeking, though Latino adolescent victims were more likely than non-Latinos to seek help, suggesting that minority status may increase the likelihood to reach for help regardless of gender. Regarding who gave each form of help, in line with the literature, males were significantly less likely than females to give all forms of help to their friends according to multiple variable regression analyses. One unexpected finding is that Latinos were significantly more likely to take action to help their friends than non-Latinos. After controlling for ethnicity and gender, data showed that foreign-born adolescents (of which 80 % were Latino) were less likely than US-born young people to both talk to and suggest options to their friends, while there was no difference between the two for taking action with or on behalf of their friend in a violent relationship. Further exploration is needed regarding Latino and foreign-born adolescents' help-giving to friends experiencing relationship violence. Specifically, future research could inquire as to whether forms of help-giving are encouraged in part by family and peer socialization and by overall cultural value systems.

This is the first paper to ask adolescent help-givers to self-report the help they provide, the first to provide information on which forms of help are most often given as well as who is most likely to give it, and among the first to assess how ethnicity and nativity affect help-seeking. Beyond the need for replication—including in adolescent samples with different ethnic compositions—a logical next step for research is to document which forms of help are perceived by the victim to be most helpful and are associated with the most positive outcomes. Research suggests that informal help-giving may not always have positive outcomes,^{35–37} and determining which approaches are most successful would be instrumental in beginning to craft adolescent programs that educate adolescents about help-giving strategies. One limitation of the present study is that the help-giving questions are of self-reported behaviors, and it was not possible to cross-validate or match responses with those of the victims on help received. By recruiting both victims of relationship violence and the peers that helped them, the degree of agreement between them on the nature of the help provided can be assessed, and it could be determined whether research on help-giving is most accurately done with samples comprised of victims, help-givers, or both. Although our data do not allow such analyses, future research would also do well to explore the impact of involvement with “reciprocal” relationship violence

on adolescent help-seeking and help-giving behaviors. Lastly, the help giving questions offered a limited number of categories for the types of help offered or accepted. Qualitative research might assist in a more finely grained understanding of how adolescents define their own approaches.

Although policy implications may be premature, clearly adolescents often rely on each other for support in facing relationship violence, so it is important that adolescents receive training and education on how to best help their friends, including when and how to make referrals to more formal services. Programs already exist that could provide a model framework for peer program development, including bystander intervention programs such as Mentors in Violence Prevention,³⁸ relationship violence interventions such as the Safe Dates evaluated school-based curriculum which includes help-giving training for adolescents,³⁹ and peer crisis intervention models such as the Rape Crisis Advocate model from the sexual violence field⁴⁰ and System Navigators from the HIV field.⁴¹ These four programs train volunteers (often peers and members of the community) in crisis response skills such as active listening as well as how to navigate formal systems to provide support to the person in crisis.

Adolescents are often the first and last resources in supporting adolescent relationship violence victims—and it is for this particular reason that researchers and policymakers alike should further our understanding of and response to this valuable role played by adolescent peers of victims.

ACKNOWLEDGMENTS

This research was supported by funding from the New York City Council and the Centers for Disease Control and Prevention (CDC). The views expressed are those of the authors and do not necessarily represent the policies or views of the funders.

REFERENCES

1. Rennison CM. *Special Report: Intimate Partner Violence and Age of Victim, 1993–99*. U.S. Department of Justice, Bureau of Justice Statistics. 2001.
2. O’Leary KD. Developmental and affective issues in assessing and treating partner aggression. *Clin Psychol Sci Pract*. 1999; 6: 400–14.
3. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2007. *Morbidity and Mortality Weekly Report*. 2008;57(SS-4).
4. Halpern CT, Oslak SG, Young ML, Martin SL, Kupper LL. Partner violence among adolescents in opposite-sex romantic relationships: findings from the National Longitudinal Study of Adolescent Health. *Am J Public Health*. 2001; 91(10): 1679–85.
5. Hanson MJ. Health behavior in adolescent women reporting and not reporting intimate partner violence. *J Obstet Gynecol Neonatal Nurs*. 2010; 39: 263–76.
6. Gidycz CA, Orchowski LM, King CR, Rich CL. Sexual victimization and health-risk behaviors: a prospective analysis of college women. *J Interpers Violence*. 2008; 23(6): 744–63.
7. Ackard DM, Eisenberg ME, Neumark-Sztainer D. Long-term impact of adolescent dating violence on the behavioural and psychological health of male and female youth. *J Pediatr*. 2007; 151(5): 476–81.
8. Eaton DK, Davis KS, Barrios L, Brener ND, Noonan RK. Associations of dating violence victimization with lifetime participation, co-occurrence, and early initiation of risk behaviors among U.S. high school students. *J Interpers Violence*. 2007; 22: 585–602.
9. Silverman JG, Raj A, Clements K. Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. *Pediatrics*. 2004; 114: 220–5.

10. Ackard DM, Neumark-Sztainer D, Hannan P. Dating violence among a nationally representative sample of adolescent girls and boys: associations with behavioral and mental health. *J Gend Specif Med.* 2003; 6(3): 39–48.
11. Ackard DM, Neumark-Sztainer D. Date violence and date rape among adolescents: associations with disordered eating behaviors and psychological health. *Child Abuse Negl.* 2002; 26: 455–73.
12. Silverman JG, Raj A, Mucci L, Hathaway J. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *JAMA.* 2001; 286: 573–9.
13. Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical health consequences of physical and psychological intimate partner violence. *Arch Fam Med.* 2000; 9(5): 451–7.
14. Ashley OS, Foshee VA. Adolescent help-seeking for dating violence: prevalence, sociodemographic correlates, and sources of help. *J Adolesc Health.* 2005; 36: 25–31.
15. Ocampo BW, Shelley GA, Jaycox LH. Latino teens talk about help-seeking and help-giving in relation to dating violence. *Violence Against Women.* 2007; 13(2): 172–89.
16. Weisz AN, Tolman RM, Callahan MR, Saunders DG, Black BM. Informal helpers' responses when adolescents tell them about dating violence or romantic relationship problems. *J Adolesc.* 2007; 30(5): 853–68.
17. Carlson BE, McNutt L, Choi DY, Rose IM. Intimate partner abuse and mental health: the role of social support and other protective factors. *Violence Against Women.* 2002; 8: 720–45.
18. Waldrop AE, Resick PA. Coping among adult female victims of domestic violence. *J Fam Violence.* 2004; 19: 291–302.
19. Goodman L, Dutton MA, Vankos N, Weinfurt K. Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women.* 2005; 11(3): 311–36.
20. Fry, D., Davidson, L.L., Rickert, V.I. Lessel, H. *Partners and peers: sexual and dating violence among NYC youth.* A research report by the NYC Alliance against Sexual Assault in Conjunction with the Columbia University Centre for Youth Violence Prevention. New York: New York City Alliance Against Sexual Assault; 2008.
21. Ansara DL, Hindin MJ. Formal and informal help-seeking associated with women's and men's experience of intimate partner violence in Canada. *Soc Sci Med.* 2010; 70: 1011–8.
22. Courtenay WH. Key determinants of the health and well-being of men and boys. *Int J Men's Health.* 2003; 2(1): 1–30.
23. Jaffe P, Sudermann M, Reitzel D, Killip S. An evaluation of a secondary school primary prevention program on violence in intimate relationships. *Violence Vict.* 1992; 7: 129–46.
24. Krogan S. Disclosing unwanted sexual experiences: results from a national sample of adolescent women. *Child Abuse Negl.* 2004; 28(2): 147–65.
25. Foshee VA, Linder GF, Bauman KE, Langwick SA, Arriaga XB, Heath JL, et al. The safe dates project: theoretical basis, evaluation, design, and selected baseline findings. *Am J Prev Med.* 1996; 12(5): 39–47.
26. Liang B, Goodman L, Tummala-Narra P, Weintraub S. A theoretical framework for understanding helpseeking processes among survivors of intimate partner violence. *Am J Community Psychol.* 2005; 36: 71–84.
27. Beeble ML, Lori A, Post DB, Sullivan CM. Factors related to willingness to help survivors of intimate partner violence. *J Interpers Violence.* 2008; 23(12): 1713–29.
28. Gallopin C, Leigh L. Teen perceptions of dating violence, help-seeking and the role of schools. *Prev Res.* 2009; 16: 17–20.
29. Jackson SM, Cram F, Seymour FW. Violence and sexual coercion in high school students' dating relationships. *J Fam Violence.* 2000; 15: 23–36.
30. McPherson JM, Smith-Lovin L, Cook JM. Birds of a feather: homophily in social networks. *Annu Rev Sociol.* 2001; 27: 415–44.
31. Ullman SE. Social support and recovery from sexual assault: a review. *Aggress Violent Behav: Rev J.* 1999; 4(3): 343–58.

32. Campbell R. The psychological impact of rape victims' experiences with the legal, medical, and mental health systems. *Am Psychol.* 2008; 63: 702–17.
33. Symons PY, Groer MW, Kepler-Youngblood P, Slater V. Prevalence and predictors of adolescent dating violence. *J Child Adolesc Psychiatr Nurs.* 1994; 7(3): 14–23.
34. Martin AJ, Berenson KR, Griffing S, Sage RE, Madry L, Bingham LE, et al. The process of leaving an abusive relationship: the role of risk assessments and decision-certainty. *J Fam Violence.* 2000; 15(2): 109–22.
35. Trotter JL, Allen NE. The good, the bad and the ugly: domestic violence survivors experience with their informal social networks. *Community Psychol.* 2009; 43(4): 221–31.
36. Goodkind JR, Gillum TL, Bybee DI, Sullivan CM. The impact of family and friends' reactions on the well-being of women with abusive partners. *Violence Against Women.* 2003; 9: 347–73.
37. West A, Wandrei ML. Intimate partner violence: a model for predicting interventions by informal helpers. *J Interpers Violence.* 2002; 17: 972–86.
38. Katz J, Heisterkamp HA, Fleming WM. The social justice roots of the Mentors in violence prevention model and its application in a high school setting. *Violence Against Women.* 2011; 17: 684–702.
39. Foshee VA, Bauman KE, Ennett ST, Suchindran C, Benefield T, Linder GF. Assessing the effects of the dating violence prevention program 'safe dates' using random coefficient regression modelling. *Prev Sci.* 2005; 6(3): 245–58.
40. Campbell R. Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence Against Women.* 2006; 12(1): 30–45.
41. Vargas RB, Cunningham WE. Evolving trends in medical care-coordination for patients with HIV and AIDS. *Curr HIV/AIDS Rep.* 2006; 3(4): 149–53.
42. Zeitler MS, Paine AD, Breitbart V, Rickert VI, Olson C, Stevens L, et al. Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. *J Adol Med.* 2006; 39: 119.e1–e8.

Publication 5

Fry, D. (2007). *How S.A.F.E. is NYC? Sexual Assault Services in Emergency Departments*. New York City Alliance Against Sexual Assault: New York.

Copyright permission obtained from the NYC Alliance Against Sexual Assault to use and archive this research report within this PhD by Publications thesis.

APRIL 2007

How SAFE is New York City? Sexual Assault Services in Emergency Departments

**A Research Report
from the New York City Alliance
Against Sexual Assault**



How SAFE is New York City: Sexual Assault Services in Emergency Departments

By Deborah Fry



**New York City Alliance
Against Sexual Assault**

Published by the
New York City Alliance Against Sexual Assault

27 Christopher Street, 3rd Floor
New York, NY 10014
Phone: 212.229.0345
Fax: 212.229.0676
research@nycagainstrape.org
www.nycagainstrape.org

First printing: April 2007
Editor: Jennifer Tierney
Report design: Scott Santoro, Worksight

Copyright © 2007
New York City Alliance Against Sexual Assault
All rights reserved
Printed in the United States

Foreword

I am pleased to present *How SAFE is NYC? Sexual Assault Services in Emergency Departments*, the first comprehensive research report from the New York City Alliance Against Sexual Assault on New York City's acute care response to sexual violence. The Alliance is unique in New York State since we conduct sound evidence-based research and systems-based advocacy to ensure that *all* survivors have access to the best care. The Alliance is one of two New York State-certified Sexual Assault Examiner Training Programs in the city that train health clinicians to provide specialized care to sexual assault patients. We develop trainings and foster collaboration among healthcare, rape crisis and criminal justice personnel to improve their response to sexual assault survivors.

This report underscores how Sexual Assault Forensic Examiner (SAFE) Centers of Excellence provide the most comprehensive care for sexual assault patients in the acute care setting in NYC. However, the findings also document unequal access to these programs. SAFE Centers of Excellence are scattered throughout the five boroughs in no systematic fashion. Current ambulance guidelines dictate that sexual assault patients be brought to the facility nearest to patient pick-up location, regardless of SAFE program availability. Sexual assault victims who choose walk-in service at an ED generally do not know that specialized services do exist for their care or even where they are located. As a result, it is possible that sexual assault patients go to facilities without specially trained staff or victim advocates to help them through the emergency department process.

This groundbreaking study by the Alliance provides an assessment of the services available for sexual assault patients in NYC's emergency departments. We hope this study will serve as a baseline for future outcomes studies and as an impetus for a strategic plan to improve care. The companion study, *A Room of Our Own: Survivors Evaluate Services*, examines survivors' experiences when they sought care immediately after a sexual assault, in hospitals and rape crisis centers and with the law enforcement and criminal justice systems. Together these reports highlight the progress toward quality care for victims of sexual violence and the deficiencies that still exist. These findings give policy makers, service providers and advocates concrete data on which to base their efforts to create the best medical treatment, forensic evidence collection, advocacy and follow-up care in all hospitals. We hope you will join us in the movement to ensure best care for *all* survivors in NYC.



Harriet Lessel, Executive Director
New York City Alliance Against Sexual Assault
February 2007

Acknowledgements

This study was conducted by Deborah Fry, Research Director at the New York City Alliance Against Sexual Assault.

This study would not have been possible without the dedicated volunteer work of Sara Kane, a graduate from the John Jay College of Criminal Justice, who conducted field work and provided comments on drafts of the final report.

The Alliance is indebted to the many hospital professionals, in both ED and SAFE Programs, the directors and staff who gave their time and expertise in the completion of our survey.

Special thanks to: the pilot sites for the study who gave us excellent feedback on the survey instrument; the Operations, Standards and Training Committee and the Criminal Justice Collaboration Committee for their valuable insight on the survey instrument and implementation strategies; and all the stakeholders from the medical field who commented on drafts of this report.

The Alliance's Research Advisory Committee provides their guidance and feedback on all of our research projects, including this study: Larry Busching (Chief, Family Court Division of the NYC Law Department and a member of the Alliance's Board of Directors); Susan Xenarios, LCSW (Director of the Crime Victims Treatment Center at St. Luke's-Roosevelt Hospital and a member of the Alliance's Board of Directors); Donna Gaffney, MA, MSc, RN, DNSc (Associate Professor, Seton Hall University); Victoria Frye, MPH, DrPH (Research Investigator at the NY Academy of Medicine); Catherine Stayton, MPH, DrPH (Director of the Injury Epidemiology Unit, Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene); Cari Olson, MPH (Injury Epidemiology Research Director, Injury Epidemiology Unit, Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene); Marielis Rivera, MPH (Health Educator at the South Bronx Health Center for Children and Families); Karen Terry, PhD (Deputy Executive Officer, Program of Doctoral Studies in Criminal Justice at John Jay College of Criminal Justice); and Heath Grant, MA, MPhil, PhD (Assistant Professor at the John Jay College of Criminal Justice). We are particularly indebted to Dr. Terry and Dr. Grant for their support on the conceptualization of this project as a baseline for outcomes research.

Additional thanks also go to the following Alliance staff: Tamara Pollak, MPH, RN (Training and Education Director) for her guidance and expertise throughout the entire study; Jennifer Tierney (Communications Director) for her editorial support, Harriet Lessel, LCSW (Executive Director) for her unwavering vision, support and patience throughout the research process, Daisy Deomampo, MA (Research Associate) for her feedback on the final report, Katie Bower, MSW, a 2006 social work policy student from Columbia University for her feedback and collaboration in drafts of the final report; and Lauren Mills, a 2007 social work policy student from Columbia University for writing the timeline and several text boxes and feedback support on the final report. A big thank you to Emily Fries for her help in compiling the references for this report.

We also thank the New York State Department of Health for their feedback on the report and assistance to hospitals in developing Centers of Excellence.

Finally, our sincere gratitude is expressed to our funder, the New York State Department of Criminal Justice Services, whose staff recognized that this study will provide a strong foundation for all future efforts to better serve survivors of sexual violence.

About the Author

Deborah Fry is the Research Director at the New York City Alliance Against Sexual Assault. At the Alliance, Deborah works on citywide research projects, all geared to helping improve service delivery for survivors in NYC and evaluating current prevention and intervention programs. Current projects include this study and *A Room of Our Own: Survivors Evaluate Services*. In addition to conducting primary research, Deborah also provides research technical assistance to the NYC rape crisis programs. Deborah has a Masters of Arts degree from the Maxwell School of Citizenship and Public Affairs at Syracuse University and her Masters in Public Health from Columbia University. Deborah was also a Fulbright Research Scholar from 2001 to 2002.

Table of Contents

Foreword	i	Table 7: Testing for STIs by Hospital ED Type	21
Acknowledgments	ii	Table 8: Storage of NYS Sexual Offense Evidence Collection Kits, Chain of Evidence and Patient Notification	30
Glossary	iii	Table 9: Follow-up Care by Hospital ED Type	36
Executive Summary	1	Table 10: Types and Availability of Victim Advocates by Hospital ED Type	38
Introduction	5	Table 11: Quality Assurance Variables by Hospital Type	42
Medical care	13	Table 12: Summary of Recommendations Based on Study Findings	49
Forensic Evidence Collection	23	Figures	
Information, Advocacy and Follow-up Care	33	Figure 1: Availability of Literature for Sexual Assault Patients by Hospital ED Type	34
Quality Assurance	41	Figure 2: Percentage of EDs with On-call Schedules for Victim Advocates by Borough	39
Implications	45	Text Boxes	
References	51	Pioneers in Best Care: The First SAFE Programs in NYC	8
Appendix A: Methodology	55	A Brief History of Emergency Contraception in New York State	18
Appendix B: Survey Instrument	59	Magnification for Injury Detection: The Use of Colposcopy with Sexual Assault Patients	26
Appendix C: Timeline of Legislation	67	The Importance of Rape Crisis Advocates	40
Tables		Quality Assurance Frameworks	43
Table 1: Emergency Department Survey Response Rates by Borough	10		
Table 2: Overview of Reported ED Level of Service by Hospital Type and Borough	11		
Table 3: Percentage of EDs with On-call and Back-up On-call Schedules for SAFE Clinicians	14		
Table 4: Amount of Time Before SAFE or On-call Doctor Arrives at ED Once Called	15		
Table 5: Average Length of Stay in ED and Exam Time by Hospital Type	17		
Table 6: Reported Minimum Ages for Using Adult Protocol for Sexual Assault Patients	19		

Glossary

ADA	Assistant District Attorney
AI	Appreciative Inquiry
CAC	Child Advocacy Center
CME	Continuing Medical Education
COPE	Client-Oriented, Provider-Efficient Services
CVB	Crime Victims Board
DCJS	Division of Criminal Justice Services
DFSA	Drug Facilitated Sexual Assault
DOH	Department of Health
ED	Emergency Department
HHC	Health and Hospitals Corporation
HIV PEP	HIV Post Exposure Prophylaxis
IAFN	International Association of Forensic Nurses
MRDD	Mental Retardation/Developmental Disability
Non-SAFE	Hospital emergency department <i>without</i> a certified SAFE program

NYS DCJS	New York State Division of Criminal Justice Services
NYS DOH	New York State Department of Health
NYS Protocol	NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault
QA	Quality Assurance
QI	Quality Improvement
RCP	Rape Crisis Program
SAE	Sexual Assault Examiner
SAFE clinician	Sexual Assault Forensic Examiner
SAFE Program	Sexual Assault Forensic Examiner Program
SANE	Sexual Assault Nurse Examiner
SARA	Sexual Assault Reform Act
SART	Sexual Assault Response Team
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing
WL	Wood's Lamp

Executive Summary

“...And he raped her. When he was gone she called 911 and the police came and took her to the hospital. And then something remarkable happened. She was treated with sensitivity and great care by people whose only duties were to look after her...explaining what was happening and giving her back her sense of dignity and safety.” (Quindlen, 1994).

Public attention was drawn to the development of Sexual Assault Examiner Programs in 1994, when Anna Quindlen described the Tulsa, Oklahoma, Sexual Assault Nurse Examiner program in a *New York Times* editorial (October 19, 1994). Quindlen contrasted the Tulsa program with a negative experience reported by a rape survivor in a Brooklyn hospital. She was writing about a problem well understood by rape crisis advocates: how getting help sometimes made it worse for rape victims.

Ten years later, Sexual Assault Forensic Examiner (SAFE) programs, as they are known in New York, have come to national prominence as one way to accomplish the collaboration between victim advocates, the healthcare sector and the criminal justice system promoted by the Violence Against Women Act. However, it is clear that optimal medical care and forensic evidence collection still do not routinely occur in hospital emergency departments.

This study was conducted to map what services currently exist in NYC emergency departments (EDs) for patients reporting a sexual assault. ED Directors or SAFE Medical Directors from 39 of the 63 emergency departments in the city were interviewed in-person or by telephone. Randomly chosen practitioners were also interviewed from 23 of the 39 EDs that responded to the survey. The survey consisted of 104 questions on the details of patient care for sexual assault victims in the acute care setting. The survey was piloted and data collected over eight months from April 2005 to December 2005. All, but one, of the currently certified SAFE Centers of Excellence participated in the study. We can infer those emergency departments that did

not respond are likely not to offer comprehensive care for sexual assault patients.

New York City has more EDs than any other city in the United States. Its large population and concentration of many public and private EDs present unique challenges for the provision of the best care for all sexual assault survivors. This report provides a comprehensive assessment of the acute sexual assault services available through NYC emergency departments. Chapter 1 defines the evidence base for SAFE programs and describes SAFE program components. Chapter 2 presents key findings regarding the medical care of sexual assault patients. Chapter 3 details the research findings related to forensic evidence collection and chain of evidence maintenance. Chapter 4 examines findings around advocacy, information-giving and follow-up care for sexual assault survivors. Chapter 5 explores the data around quality assurance and discusses ways to improve the acute care response. Chapter 6 concludes the report with implications of the findings for advocacy and future research. This is the second mapping of the acute sexual assault services available in NYC. The first was conducted by the Rape Treatment Consortium in partnership with the Barnard/Columbia Center for Urban Policy in 1996. The Consortium interviewed via phone and through mail surveys social workers and other hospital staff at 45 hospitals. They asked questions on eight areas: forensically trained personnel, site of exam, advocates, training, follow-up care, administration, financial support and outreach and education. This effort by the Consortium served as formative research for this comprehensive study.

Key Terms Used in This Report

This report looks at the difference between emergency departments with specialized sexual assault programs called Sexual Assault Forensic Examiner (SAFE) Centers and those who offer a varying

degree of such services. In this report we refer to SAFE Centers and SAFE programs also as SAFE Centers of Excellence, a designation given by the New York State Department of Health (NYS DOH) for programs that meet certain criteria for comprehensive care to sexual assault patients in the acute care setting. SAFE Centers of Excellence also include Sexual Assault Response Teams (SART), a model of comprehensive care across a network of hospitals. SARTs exist primarily at public hospitals in each borough, except Staten Island.

Furthermore, there are also Sexual Assault Examiner (SAE) programs in the city. These programs are funded through the New York State Division of Criminal Justice Services. All of these programs are also SAFE Centers of Excellence except for one. In this report, SAFE Centers also refers to these SAE programs. To make this even more confusing, many other states refer to their specialized programs as Sexual Assault Nurse Examiner (SANE) programs. We use the term SAFE in New York State because other clinicians, not just nurses, can be specially trained to provide comprehensive care to sexual assault patients in the acute care setting.

Specially trained doctors, nurses, nurse practitioners and physicians assistants are also called SAFEs, or Sexual Assault Forensic Examiners. To distinguish between SAFEs that are programs and SAFEs that are practitioners, we utilize the term SAFE clinician to refer to specially trained hospital staff.

In this report, the term victim advocate refers to hospital social workers, other hospital staff and volunteers who provide crisis counseling and advocacy services to sexual assault patients in the acute care setting. Those who undergo 40 hours of training at a local rape crisis program to provide advocacy services in the emergency department are called volunteer victim advocates.

Key Findings

The Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Response Team (SART) Programs surveyed offer the most comprehensive care to sexual assault patients in NYC's emergency departments.

Eleven emergency departments in study were SAFE Centers of Excellence (which includes Sexual Assault Response Teams, or SARTs), and 28 emergency departments are non-SAFE, meaning that they do not have a NYS DOH-certified comprehensive Sexual Assault Examiner Program in place at their emergency department. The SAFE and SART Programs surveyed all utilize specially trained doctors and nurses to conduct rape exams. These programs are more likely to have specialized equipment, such as colposcopes and swab dryers, than non-SAFE/SART programs. SAFE/SART programs also report providing more information, advocacy and follow-up care for patients reporting a sexual assault than non-SAFE/SART emergency departments.

All public hospitals surveyed provide comprehensive care for sexual assault patients in their emergency departments.

Ten public hospital emergency departments were surveyed, half of which had a SAFE Center of Excellence at the time of this study. Along with a few pioneering private hospital emergency departments, the public hospitals have been the leaders in providing specialized care for sexual assault patients in NYC. All of the public hospitals surveyed reported having SAFE clinicians and nearly all reported having specialized equipment. All public hospitals surveyed also utilize victim advocates and reported that they refer all patients for follow-up counseling. These public emergency departments also report always using the standardized NYS Evidence Collection Kit and Drug Facilitated Sexual Assault Kit (DFSA), and all report that they have capacity to store DFSA kits at their emergency departments. The public emergency departments also report systems of quality assurance for sexual assault services and routine chart audits on sexual assault cases.

SAFE programs are scattered throughout the city in no systematic fashion.

All of the 11 SAFE Centers of Excellence as of December 1, 2005 are represented in this study. Most of these specialized emergency departments are located in Manhattan (46%) and Brooklyn (27%), with many fewer in the Bronx (18%) and Queens (9%). One hospital emergency department on Staten Island has received funding to begin a SAFE program. According to ambulance rules, a sexual assault patient must be transported to the facility nearest to the pick-up locations. Given the haphazard location of SAFE/SART programs across NYC, many sexual assault victims may have *unequal* access to the best medical care, based on where programs are located. Furthermore, many patients also walk into emergency departments without knowledge of whether they have specialized services. There has been no public information campaign about what SAFE Centers are and where they are located. As of February 2007, five additional emergency departments have become SAFE Centers of Excellence, totaling 17 EDs (NYS DOH, 2006a).

The majority of emergency departments surveyed utilize rape victim advocates, although very few have only volunteer advocates.

All of the SAFE Centers of Excellence use victim advocates for sexual assault patients, as do 85.7% of non-SAFE emergency departments. Another 31.4% of all EDs report only utilizing volunteer community advocates. Most EDs (48.5%) report using a combination of hospital social workers, other hospital staff and volunteer advocates. Our companion report, *A Room of Our Own: Survivors Evaluate Services*, documents how the presence of a *volunteer* victim advocate had a statistically significant impact on the survivors' satisfaction with the care they received at the hospital.

Emergency departments with SAFE programs are more likely to have specialized equipment or other enhancements for forensic evidence collection.

Emergency departments surveyed with a SAFE program are more likely to report dedicated colposcopes that can magnify injuries (100% vs. 28.6%), swab dryers that shorten exam time and ensure that swabs are dried before being put in the evidence collection kit (72.7% vs. 11%), and Woods lamps that can detect fluids including semen on the body and clothes (90.9% vs. 67.8%). Emergency departments surveyed with SAFE programs are also more likely than emergency departments without SAFE programs to report having a procedure in place for photo documentation of injuries (100% vs. 85.7%), a record log of the release of an evidence kit to the police that ensures the chain of evidence is maintained (100% vs. 81.5%), the capacity to store evidence kits for longer than three months (90.9% vs. 33.3%), and a medical staff person who has been trained in testifying in court (100% vs. 60.7%). All these elements can factor into criminal justice outcomes.

Emergency contraception and HIV post-exposure prophylaxis (PEP) is provided in nearly all EDs surveyed, regardless of the presence of a SAFE program.

All of the hospital emergency departments surveyed, regardless of whether they have a SAFE or SART program, reported routinely providing emergency contraception to sexual assault patients. All of the SAFE programs surveyed report that the emergency contraception is obtained from the hospital staff, whereas 7.1% of non-SAFE programs report that the patient must obtain the EC from an in-house pharmacy. Overall, 97.4% of the emergency departments surveyed report providing sexual assault patients with HIV post-exposure prophylaxis, where medically indicated. However, SAFE programs report that they always make follow-up appointments for HIV PEP, compared to only 60.7% of non-SAFE programs.

Chapter 1: Introduction

Defining SAFE/SART Programs

In New York State, many hospitals have developed Sexual Assault Forensic Examiner (SAFE) programs, also called Sexual Assault Nurse Examiner (SANE) programs, to provide specialized care to sexual assault patients. NYS legislation enacted in 2000, known as the Sexual Assault Reform Act (SARA), mandates that the NYS Department of Health (NYS DOH) formally designate hospital emergency departments as the sites of 24-hour SAFE programs. Hospitals interested in applying for designation as SAFE Programs must meet specific criteria and submit applications to the NYS DOH.

According to the NYS DOH *Protocol for Acute Care of the Adult Patient Reporting Sexual Assault*, “the primary mission of a SAFE program is to provide immediate, compassionate, culturally sensitive and comprehensive forensic evaluation and treatment by specially trained sexual assault forensic examiners in a private, supportive setting to all victims of sexual assault, regardless of whether or not they choose to report to law enforcement. Specifically, the goals of the SAFE program are to:

1. Provide timely, compassionate, patient-centered care in a private setting that provides emotional support and reduces further trauma to the patient;
2. Provide quality medical care to the patient who reports sexual assault, including evaluation, treatment, referral and follow-up;
3. Ensure the quality of collection, documentation, preservation and custody of physical evidence by utilizing a trained and New York State Department of Health (DOH) certified sexual assault forensic examiner to perform the exam, which may lead to increased rates of identification, prosecution and conviction of sexual assault perpetrators;
4. Utilize an interdisciplinary approach by working with rape crisis centers and other service providers, law enforcement and prosecutors’

offices to effectively meet the needs of sexual assault victims and the community;

5. Provide expert testimony when needed if the survivor chooses to report the crime to law enforcement; and,
6. Improve and standardize data collection regarding the incidence of sexual assault victims seeking treatment in hospital emergency departments” (NYS DOH, 2004).

The NYS DOH protocol also details the standard for treatment of survivors in emergency departments throughout the state. To become a Sexual Assault Forensic Examiner, a health clinician should attend a NYS DOH-certified training program, such as the training program offered through the NYC Alliance Against Sexual Assault, which is a five-day comprehensive course on medical and forensic treatment. These health clinicians must then complete a preceptorship or ‘mentoring’ with a certified examiner to complete the process. If a health clinician was trained as a SAFE elsewhere, they can have their training reviewed by a NYS DOH certified training program to become certified in NYS. Furthermore, if a health clinician is certified by the International Association of Forensic Nurses (IAFN), they are eligible to apply to NYS DOH to become a certified SAFE clinician. An emergency department can have a SAFE-trained examiner, even if they do not have a full SAFE program.

To become a specialized SAFE Center of Excellence designated by NYS DOH, a hospital or other center must meet the following criteria beyond what is required by state law:

1. Maintain a designated and appropriately equipped private room in or near the hospital’s emergency department to meet the specialized needs of sexual assault patients. Accommodations must include access to a shower and be handicap accessible.

2. Maintain a supply of and provide an initial supply to patients, as medically indicated, of prophylaxis for HIV.
3. Establish an organized program/service specifically to carry out and oversee the provision of sexual assault services. This would include the development and implementation of policies and procedures detailing staffing requirements, initiating and conducting community outreach programs, participating in an organized data collection system, and routinely following-up with patients/law enforcement officials and crime laboratory personnel regarding the credibility of evidence collection activities.
4. Designate a program coordinator to exercise administrative and clinical oversight for the program.
5. Ensure that the program includes a cohort of specially trained Sexual Assault Forensic Examiners (SAFEs) who have been prepared through an intensive classroom and preceptor training program and have been certified by NYS DOH to conduct sexual assault exams.
6. Establish/participate in an interdisciplinary taskforce that includes local rape crisis centers, other service agencies, and law enforcement representatives/local prosecutors to develop services that meet community needs and to ensure that quality victim services are available.
7. Provide Sexual Assault Forensic Examiners on-site or on-call available to the patient within 60 minutes of arriving at the hospital, except under exigent circumstances.
8. Routinely use the New York State Evidence Collection Kit, if the patient consents to having evidence collected.
9. Coordinate outreach activities in the community and with other hospitals to share best practices, provide training opportunities and promote the availability of programs, to the extent feasible.
10. Participate in regional and statewide quality assurance initiatives designed to measure program effectiveness and meet reporting requirements (NYS DOH, 2004).

In February 2005, NYC Mayor Michael Bloomberg issued a mandate for all eleven Health and Hospital Corporation (HHC) emergency departments (NYC's public hospitals) to develop SAFE Centers of Excellence by September 2005 (NYC, 2005). Each of the emergency departments complied with this mandate facilitating the development of HHC Sexual Assault Response Teams (SART) in Bronx, Brooklyn, Manhattan and Queens. The HHC SARTs operate similarly to SAFE programs, except that the SAFE clinicians and victim advocates can travel to any of the HHC hospitals within a specific borough to provide care.

Regardless of whether a hospital emergency department has a SAFE or SART program, every hospital in New York State must ensure that all victims of rape or sexual assault who present at the hospital are provided with care that is comprehensive and consistent with current standards of practice. By Public Health Law (Section 2805-i) entitled Treatment of Sexual Offense Victims and Maintenance of Evidence in a Sexual Offense (2002), every hospital in New York State must provide treatment to victims of a sexual offense and be responsible for:

1. Maintaining sexual offense evidence and chain of custody, and
2. contacting a rape crisis program or victim assistance organization, if any, providing victim assistance to the geographic area served by the hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services.

Thus, by law, the patient must be told about the local rape crisis services and given the option of a rape crisis advocate to accompany him/her during the exam if s/he wishes. Furthermore, in 2003, Local Law 26 was passed, which states that New York City requires hospitals to provide victims with information about emergency contraception and to document whether or not emergency contraception was given to rape victims when medically appropriate (NYC Council, 2006a). The NYS Department of Health was charged with developing and producing informational materials on emergency contraception to be used by all hospitals in New York State. These materials are currently available in eight languages.

National and Local Evolution of SAFE/SART Programs

In the past, victims of sexual assault seeking medical attention often experienced victim-blaming attitudes and substandard care. Rape Crisis Programs arose in the 1970s both nationally and in NYC as a movement to provide care to sexual assault survivors. These victim advocates then began to develop local, state and national reforms to address standard-of-care problems within hospitals. Within the last thirty years, SANE/SAFE programs have been created throughout the United States. There were only three known programs in the 1970s, 13 by the end of the 1980s, 86 by the mid-1990s, and the current estimate of national SANE programs numbers more than 450 (Campbell, Patterson & Lichty, 2005; Ledray, 2005). In 1992, the first international meeting of SANEs was held with representatives from the US and Canada, and the International Association of Forensic Nurses was formed (Campbell, Patterson & Lichty, 2005).

Many hospitals in NYC operate Sexual Assault Response Teams (SARTs). A SART brings together professionals to work with a patient reporting sexual assault. This team traditionally includes acute care professionals, victim advocates, the police and prosecutors. This model is used by many states with mandated reporting laws (e.g., if a patient presents for care following a sexual assault, a healthcare provider must first involve law enforcement before conducting a forensic exam). New York State does not have a mandated reporting law for sexual assault, so SARTs look slightly different than in other localities. Therefore, in NYC, a hospital that participates in a SART shares Sexual Assault Forensic Examiners with other hospitals in the network. This allows for a core team of specially trained medical professionals to respond to in-network health facilities. The SAFE responds to a case of sexual assault with a victim advocate. The SARTs work closely with both law enforcement and criminal justice, but it is still the victim's choice to report the case. The New York State Department of Health (NYS DOH) refers to SARTs as 'regional network models' (NYS DOH, 2004).

Overall, 17.9% (7/39) of the EDs in this study's sample participate in a SART. SARTs exist in the

public hospitals, though some private hospitals may also share examiners in the same network. Mayor Bloomberg announced a strategy to expand SART programs to public hospitals citywide. As of fall 2005, SART programs existed in Brooklyn and the Bronx and had been launched in Manhattan and Queens (NYC, 2005). There are no public hospitals in Staten Island.

The first SART program began in NYC in 2004 in the Bronx as a joint initiative through the Mayor's office and the Health and Hospitals Corporation (HHC), which runs the public hospitals. The Bronx SART program consists of the three public hospitals in the Bronx, a team of 15-20 SAFE Examiners and a cadre of volunteer advocates. Anytime a patient reporting a sexual assault is seen at any of the three public hospitals, an on-call SAFE responds to the hospital within an hour on average and on-call advocates respond on average within 20 minutes.

In its first eight months, the Bronx SART program treated more than 200 sexual assault patients (Mayor's Office, 2005). According to the Mayor's Office, the Bronx SART examined more than 90% of the presenting sexual assault patients within one hour, compared to 63% in 2003 before the hospitals became a SART program. Furthermore, 83% of the sexual assault patients were examined for evidence of microscopic genital injury using a colposcope, compared to 29% in 2003 (NYC, 2005).

The number of specialized training programs throughout the country is slowly increasing. There are currently five training programs in New York State certified by the NYS DOH, two of which are in NYC. These training programs provide 40 hours of training to clinicians interested in being certified as specialized sexual assault forensic examiners. The training includes evidence collection techniques, the use of specialized equipment, chain-of-evidence requirements, expert testimony, injury detection and treatment, pregnancy and STI prophylaxis, caring for traumatized patients in the acute care setting, and crisis intervention.

Pioneers in Best Care: The First SAFE Programs in NYC

The first specialized sexual assault examiner program in New York developed as a pilot program at New York City's Bellevue Hospital in 1987.

Bellevue's sexual assault examiner program developed under the auspices of the hospital's advocacy and counseling program, Victims of Violent Assault Assistance Program (VoVAAP). This specialized acute care response program was the outgrowth of an earlier program VoVAPP initiated to provide follow-up services to sexual assault patients who had received treatment in the emergency department. The two nurse practitioners directing this follow-up care program in the mid-1980s noted that their patients consistently reported receiving poor care in the emergency room. Time and again, patients identified a poor standard of care: untrained medical residents conducting post-sexual assault exams; patients forced to wait for hours before receiving care in the emergency department; patients felt re-victimized by the comments and actions of medical staff; and, due to a lack of training, clinicians were not adept at collecting evidence for Vitullo kits (the sexual assault evidence collection kit in use at that time).

In response to this patient feedback, VoVAPP's director, Melissa Mertz, MSW, and the two nurse practitioners from the follow-up program, Verna Robertson and Susan Merguerian, secured funding from the New York State Crime Victims Board (NYS CVB) to develop a pilot sexual assault examiner program. The three clinicians traveled to Amarillo, Texas to observe one of the few national programs at this time providing state-of-the-art care to sexual assault victims in conjunction with law enforcement, prosecutors and crime lab personnel. Upon their return, with the funding from CVB and support from Lewis Goldfrank, M.D., Medical Director of Bellevue's E.D., and Linda Fairstein, Esq., Assistant District Attorney, New York County, these three women

established New York's first multi-disciplinary sexual assault examiner program. In addition to ensuring that trained, mid-level nurse practitioners were on call to respond to sexual assault patients in Bellevue's emergency room 24 hours a day, seven days a week, the program worked closely with law enforcement, counseling, and criminal justice professionals to improve care for sexual assault patients.

Following the establishment of this program, Ms. Merguerian was invited to participate in the Governor's Task Force on Rape and Sexual Assault, a multidisciplinary task force established by executive order in July, 1989 for the purpose of developing a standardized best practice protocol care of sexual assault patients. Led by Kathi Montesano-Ostrander, Director of Rape Crisis Programs for the New York State Department of Health, this task force succeeded in designing New York State's first "Adult Sexual Assault Evidence Collection Protocol." This document served as a critical step toward improving acute care of sexual assault patients in New York State.

In 1990, based on recommendations made by the Task Force, Governor Cuomo's administration approved funding for manufacturing sexual assault evidence kits, as well as training to accompany the best-practice protocol. Ms. Merguerian and Ms. Montesano-Ostrander conducted this training throughout ten regions in NYS thereby pioneering the Sexual Assault Forensic Examiner programs of today.

On October 14, 1994, the *New York Times* published Anna Quindlen's Op-ed "After the Rape." The column described the humiliating and traumatic experience of a rape victim in a New York City emergency room. This was the same year the Violence Against Women Act (VAWA) was made a federal law, a landmark piece of legislation that sought to improve criminal justice and community-based responses to domestic violence, dating violence, sexual assault and stalk-

Pioneers in Best Care *(continued)*

ing in the United States. These were two of the major events that mobilized the New York City Rape Treatment Consortium to develop specialized sexual assault forensic examiner (SAFE) programs in hospital emergency departments in New York City.

Lucy Friedman, the director of Victim's Services, assembled the consortium in 1994 to implement SAFE programs in New York City Hospitals. The consortium was comprised of rape crisis service providers, the Manhattan District Attorney's office, the NYPD, and the New York City Health and Hospital Corporation (HHC). Susan Xenarios, the then director of the Rape Crisis Intervention/Crime Victim Assessment Project at St. Luke's-Roosevelt Hospital Center, and other members of the consortium began planning and gaining support for the next Sexual Assault Forensic Examiner (SAFE) program in New York City to be piloted at St. Luke's-Roosevelt Hospital.

The consortium conducted a needs assessment of services for survivors in NYC and identified gaps in the system of care, such as the lack of specially trained acute care providers. The consortium's goal was to establish a SAFE program in every borough. DCJS provided a small grant of \$100,000 to develop the St. Luke's SAFE program, which was successfully established in 1997. Columbia University hosted a three-day training for clinicians, and eight examiners were credentialed by the hospital to respond to sexual assault patients on an on-call basis. Donna Gaffney developed the training curriculum for SAFE clinicians specifically for NYS and was among the people at the state level (along with DOH and DCJS) to develop and pilot the curriculum. Ms. Gaffney, who still offers the SAFE training program in collaboration with the Alliance and Seton Hall University, is a member of the the Alliance's Research Advisory Committee. A physician appointed to be the medical director of the SAFE program supervised the examiners.

In 1998, Long Island College Hospital started a SAFE program in Brooklyn. Shortly after, Beth Israel Hospital developed a SAFE program as well, enabling the program to be accessed by different neighborhoods of Manhattan. The training for examiners also expanded. Currently, St. Luke's-Roosevelt is the only teaching hospital in the country to mandate a five-day training for all first year residents. While not all the residents will go on to become certified SAFE examiners, the training translates into better medical practices and understanding of treating survivors of sexual assault.

On April 1, 2004, North Central Bronx Hospital (NCB) became the first member of the Sexual Assault Response Team (SART) and the first SAFE program to be certified by the New York State Department of Health. Dr. Bridgitte Alexander, an emergency room physician, researched SAFE programs in New York City and advocated for the development of a program at NCB. She is currently the Medical Director of the SART program at NCB. The program was funded by the Mayor's office and DCJS. In November of 2005, Karen Carroll was hired as the associate director of the SART program, allowing the program to be the first one to ensure coverage for rape victims twenty four hours a day seven days a week with backup. Ms. Carroll is on call twenty-four hours, so that if more than one person needs an exam, there will be a SAFE examiner on call. Ms. Carroll will be available for back-up, so a patient will not wait more than 60 minutes for an exam. SART programs in Brooklyn, Queens and Manhattan are working to follow this model.

Nearly 20 years after the advent of Bellevue's program, there are currently 17 EDs with SAFE centers in New York City hospitals (NYS DOH, 2006a). Advocacy work continues to determine the critical number of specialized programs needed to ensure that every sexual assault patient has access to specialized services.

Victim Advocates

Victim advocates are an integral part of SAFE and SART programs. They provide emotional support to victims of sexual assault in the hospital setting. Advocates accompany victims from the initial contact and the actual exam through discharge and follow-up. The more specialized and trained both sexual assault examiners and volunteer rape advocates are, the better services victims receive at the hospital. In New York City, victim advocates are either community volunteers who complete a 40-hour training administered by their local rape crisis program and overseen by the NYS DOH, or they are hospital social workers. There are currently 20 NYS DOH-funded rape crisis centers in NYC. Ten of these provide emergency room volunteer advocacy services to a total of 24 emergency departments throughout the city. There is at least one hospital in NYC that trains ancillary emergency room staff (patient-care technicians) to serve as victim advocates. All of the SAFE and SART programs in NYC are located within emergency departments. As of December 2006, 17 hospital emergency departments had earned the NYS DOH designation as SAFE Centers of Excellence in NYC (NYSDOH, 2006). This number represents 27% of the emergency departments in the city. Some hospitals may have some specific components of SAFE services available to survivors, such as utilizing rape crisis advocates, but do not have a comprehensive program in place.

Mapping Acute Care Services in NYC

This study comprehensively maps acute care service delivery in NYC for sexual assault survivors. A 104 question survey was used to interview in-person ED administrators or SAFE Medical Directors at 39 of the 63 EDs (62%) within the 5 boroughs. The survey questions were developed by examining several protocols and resources for the acute care of the sexual assault survivor (see the detailed Methodology in Appendix A).

Table 1: Emergency Department Survey Response Rates by Borough

	Response Rate % (proportion)
Total Sample	62% (39/63)
Bronx	40% (4/10)
Brooklyn	61.1% (11/18)
Manhattan	73.6% (14/19)
Queens	69.2% (9/13)
Staten Island	33.3% (1/3)
Public Hospitals	83.3% (10/12)
Private Hospitals	57% (29/51)

As seen in Table 1, the total response rate for the study was 62%, with the highest number of ED Directors responding from hospitals in Manhattan (74%) and from public hospitals (83%). Throughout the report, Bronx and Staten Island numbers are excluded from analyses where indicated due to small sample size and to protect confidentiality. For this study, data was collected for eight months from April 2005 to December 2005.

Respondents were asked if their hospital was a NYS DOH-certified SAFE Center of Excellence. Table 2 presents the distribution of SAFE Centers of Excellence and non-SAFE hospital EDs by hospital type (public and private) and borough. Less than a third (28.2%) of all emergency departments surveyed have a comprehensive SAFE Center of Excellence to care for sexual assault patients. With no NYS DOH-certified SAFE Center of Excellence on Staten Island.

Table 2: Overview of Reported Emergency Department Level of Service by Hospital Type and Borough

	Total n = 39	Public Hospitals n =10	Private Hospitals n =29	Bronx n=4	Brooklyn n=11	Manhattan n=14	Queens n=9	Staten Island n=1
SAFE Center of Excellence	28.2% (11/39)	50% (5/10)	20.7% (6/29)	25% (1/4)	36.4% (4/11)	35.7% (5/14)	11.1% (1/9)	0
Non-SAFE	71.8% (28/39)	50% (5/10)	79.3% (23/29)	75% (3/4)	63.6% (7/11)	64.3% (9/14)	88.8% (8/9)	100% (1/1)

The response rate for certified SAFE Centers of Excellence for this study was 100%: 10 hospitals representing 11 emergency departments were certified by December 2005. We can safely assume that the remainder of emergency departments are non-SAFE. While some of the non-responding hospital emergency departments in the study

have taken steps to develop SAFE programs (such as utilizing volunteer victim advocates or training healthcare providers as SAFE clinicians), none offer comprehensive SAFE services. The question arises if several boroughs have unequal access to specialized acute care for sexual assault patients.

Chapter 2: Medical Care

It is important for sexual assault patients to seek medical care after an assault. According to the *NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, “A health care assessment and evaluation must be offered to all patients reporting sexual assault, regardless of the length of time which may have elapsed between the assault and the examination” (NYS DOH, 2004).

Triage

For sexual assault patients, their first point of contact within a hospital emergency department is triage. According to the *NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, patients should be triaged immediately (NYS DOH, 2004). In a SAFE Center, once the patient is triaged, the on-call SAFE clinician is called to see the patient. In a non-SAFE program, an attending physician or medical provider will see the patient. Both SAFE and non-SAFE programs may also call a volunteer victim advocate to stay with the patient through the process of the medical exam and treatment. SAFE Centers of Excellence are required to utilize victim advocates (volunteer or hospital staff). The role and importance of advocates will be covered in-depth in Chapter 4.

This study assessed the following with regards to triage and availability of specialized staff to treat sexual assault patients: 1) whether the ED has SAFE clinicians; 2) how SAFE clinicians are trained, supported and retained; 3) the percentage of EDs that have an on-call schedule for SAFE clinicians; 4) the percentage of EDs that have a back-up on-call schedule for SAFE clinicians; 5) how long it takes for the on-call SAFE or clinician (in non-SAFE emergency departments) to arrive; and 6) how long it takes for the SART to arrive.

Examiners

Description of a SAFE Examiner

In New York State, clinicians become certified Sexual Assault Forensic Examiners by taking a five-day training course from a NYS Department of Health-certified SAFE training program and by completing a preceptorship. The five-day course covers all the topics relevant to treating a sexual assault patient in a timely and sensitive manner. The preceptorship is the process through which new examiners demonstrate that they are proficient in clinical competencies through mentored hands-on clinical experiences supervised by an experienced clinician. To promote continued learning, SAFE clinicians must complete a minimum of fifteen hours of continuing education in the field of forensic science within three years.

Availability of SAFE Clinicians

Overall, 26 of the 39 emergency departments (66.7%) have SAFE clinicians. As expected, all of the SAFE Centers of Excellence had SAFE clinicians, as did all the public hospitals surveyed. A larger proportion of Manhattan EDs had SAFE clinicians (92.9%) than those in Brooklyn (63.6%) and Queens (33.3%).

Among emergency departments with SAFE clinicians, 46.1% (12 EDs) have between 1-10 SAFE clinicians working at their hospitals, and another 46.1% reported from 11-20. In comparison, SART programs counted an average of 17 SAFE clinicians available, with a range from 15-20.

SAFE Certification Rates

It is possible for a doctor or nurse to take the five-day SAFE training course but not complete the preceptorship. We asked how many SAFE clinicians at the hospital are DOH-certified.

We found that while 82% of SAFE Centers of Excellence had 11-20 SAFE clinicians, not all were certified. Overall, 48.7% of the administrators surveyed report that their emergency department does not have any certified SAFE clinicians. Six of those emergency departments have SAFE clinicians who have completed the course but have not been precepted, and 13 have no SAFE clinicians (certified or not). This pattern of having a majority of uncertified SAFE clinicians is common across hospital type, borough and level of services offered.

Hospital administrators also were asked how they maintained professional education for SAFE clinicians:

- Nine EDs specifically mentioned NYC Alliance Against Sexual Assault trainings;
- Twelve routinely conduct in-service trainings;
- Five routinely conduct chart reviews;
- Four conduct meetings on a regular basis;
- Two regularly reviewed and updated protocols; and
- One attended conferences related to the issue of the acute care of the sexual assault patient or sent SAFE clinicians.

Availability of Specialized Staff

SAFE Centers of Excellence must be available 24 hours a day. On-call schedules for SAFE clinicians meet these requirements. In Table 3, we see that all of the SAFE Centers of Excellence have an on-call examiner schedule, and 63.6% have a back-up on-call schedule. Among non-SAFE programs, 15 EDs have trained SAFE clinicians, of which only two (13.3%) have on-call schedules for those examiners, with the difference between SAFE and non-SAFE EDs being statistically significant. While these EDs have some specific services available for response to sexual violence, they cannot guarantee 24-hour coverage. The majority (60%) of public EDs sampled have an on-call schedule, compared to 44% of private EDs.

Respondents were also asked about their ‘Plan B,’ should their on-call and/or back-up on-call schedules fail. The majority of respondents reported that the ER attending physician would see the patient. Several other respondents reported that the OB/ GYN resident would render treatment. While all EDs could treat the patient, it was not guaranteed that the provider would have any specialized experience with sexual assault survivors and forensic evidence.

Table 3: Percentage of EDs with On-call and Back-Up On-Call Schedules for SAFE Clinicians

	SAFE Center of Excellence (n=11)	Non-SAFE (n=15)
On-call schedule for SAFE Clinicians	100% (11/11)***	13.3% (2/15)
Back-up on-call schedule for SAFE Clinicians	63.6% (7/11)***	6.7% (1/15)

*** p<.001

How long it takes specialized staff to arrive

Specialized care requires that trained professionals be available to conduct the medical and forensic exam of the sexual assault patient. However, this requirement can mean longer waits for the patient. The NYS protocol (which the NYS DOH recommends all New York emergency departments use; SAFE Centers of Excellence are required to have hospital protocols that are consistent with this protocol) for treating sexual assault patients stipulates that on-call SAFE clinicians arrive at the hospital within 60 minutes (NYS DOH, 2004). Table 4 shows the amount of time before examiner arrives for SAFE and non-safe EDs. Other questions were asked of respondents who answered that they participated in a SART. Five of the seven ED respondents answered the question “How long does it take the SART to

arrive once called?” All five respondents answered that it took approximately 31-45 minutes

While emergency departments without certified SAFE programs are able, on average, to respond to patients within a shorter timeframe than certified programs, they do so without providing specialized care. At non-SAFE hospitals an emergency department clinician treats the sexual assault patient and conducts the forensic exam, even if they have not received specialized training. Given that only two non-SAFE emergency departments have on-call schedules for their specially trained SAFE clinicians, a sexual assault patient may present at the hospital when this specially trained clinician is not working, which means that another health care provider would see the patient whether they have received specialized training or not.

Table 4: Amount of Time Before SAFE or On-Call Doctor Arrives at ED Once Called

	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)
How long before SAFE or on call doctor arrives at ED?		
1–15 minutes	9.1% (1/11)	17.8% (5/28)
16–30 minutes	18.2% (2/11)	10.7% (3/28)
31–45 minutes	36.4% (4/11)	17.8% (5/28)
46–60 minutes	9.1% (1/11)	3.6% (1/28)
1–2 hours	9.1% (1/11)	—
N/A always on staff	18.2% (2/11)	50% (14/28)

Exam Area

The actual physical space in which a sexual assault patient is cared for is considered a critical component of best care. A designated space helps ensure privacy after the victim’s traumatic experience and to maintain the chain of custody for forensic evidence collection. This section covers:

- 1) The percentage of EDs with private rooms with doors designated for patients reporting a sexual assault;
- 2) the percentage of EDs offering treatment in a private area of the hospital;
- 3) the percentage of EDs with private rooms with showers;
- 4) the percentage of EDs with available showers nearby the exam area; and
- 5) the percentage of EDs with handicap-accessible private rooms or areas.

Availability of private exam rooms

Treatment in a private room is a necessity, not a luxury, for rape victims. First and foremost, it offers discretion they need. Private rooms also allow victims to stay in one place throughout the course of the examination.

Every ED surveyed (n=39) had a handicap-accessible private room with a door available for treating patients reporting a sexual assault, and all reported that sexual assault patients are treated in a private area of the hospital either 'most of the time' or 'always.' While all EDs have a room available, it may be used for other patients when there are no sexual assault patients.

Availability of showers

SAFE Centers of Excellence had a higher proportion of private rooms equipped with showers (45.5%) than non-SAFE EDs (14.2%). Among the boroughs, Brooklyn had the highest number (45.5%) of specially equipped rooms, compared to 14.3% in Manhattan and none in Queens.

If the private rooms did not have a shower, respondents were asked the availability of nearby showers. All of the Centers of Excellence without an in-room shower had one available nearby. However, 62.5% (15/24) of non-SAFE EDs reported that they did not have any shower available for patients to use after the exam.

Medical Treatment

One of the most important aspects of the acute care of sexual assault patients is ensuring that they receive medical attention for any injuries and prophylaxis for sexually transmitted infections. This section describes hospital ED administrator reports of:

1) the average length of stay in the ED for a patient reporting a sexual assault; 2) the average length of time to conduct the exam; 3) administration of pregnancy tests when applicable; 4) provision of emergency contraception, when applicable; 5) availability of emergency contraception directly from the health staff, at an in-house pharmacy or at an outside pharmacy; 6) routine testing for STIs; 7) provision of STI prophylaxis; and 8) provision of HIV prophylaxis, when applicable.

Length of Stay and Exam

One of the reasons that SAFE programs began was that exams done in a sensitive, comprehensive and victim-centered manner can take several hours. The variability in the amount of evidence collection and injury treatment for individual patients accounts for discrepancies in exam times. Table 5 shows that at SAFE Centers of Excellence most sexual assault victims (54.5%) are in the ED for an average four to six hours, whereas at non-SAFE ED visits last from two to four hours (50%). Likewise, the average length of stay in the EDs in Queens tends to be on the lower end of the spectrum (44.4% spend up to two hours and 44.4% spend two to four hours), while 45.5% of EDs surveyed in Brooklyn report that patients stay four to six hours.

Table 5: Average Length of Stay in ED and Exam Time by Hospital ED Type

	Total for all EDs in Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n= 29)
Average length of stay for patient in ED?					
0–2 hours	10.3% (4/39)	—	14.2% (4/28)	10% (1/10)	11.5% (3/29)
2–4 hours	48.7% (19/39)	45.5% (5/11)	50% (14/28)	70% (7/10)	46.2% (12/29)
4–6 hours	33.3% (13/39)	54.5% (6/11)	25% (7/28)	20% (2/10)	42.3% (11/29)
I don't know	7.7% (3/39)	—	10.7% (3/28)	—	—
Average amount of time to do the exam?					
0–1 hours	48.7% (19/39)	18.2% (2/11)**	60.7% (17/28)	20% (2/10)***	58.6% (17/29)
1–2 hours	35.9% (14/39)	45.5% (5/11)	32.1% (9/28)	40% (4/10)	34.5% (10/29)
2–3 hours	15.4% (6/39)	36.4% (4/11)	7.1% (2/28)	40% (4/10)	6.9% (2/29)

p<.01 *p<.001

For SAFE Centers of Excellence nearly one-half (45.5%) report that the average amount of time to do the exam is one to two hours, and 36.4% report an average of two to three hours. In comparison, over half (60.7%) of EDs that are non-SAFE sites report under one hour, with the difference between SAFE and non-SAFE programs being statistically significant. The public EDs report longer exam times (40% report two to three hours) than private EDs (only 6.9% report such time). This difference

between public and private hospitals on length of exam is statistically significant ($p<.001$), meaning it is highly unlikely that it occurred by chance. Brooklyn and Manhattan report similar responses, and nearly three-quarters of EDs in Queens report an average exam time up to two hours.

A Brief History of Emergency Contraception in New York State

"Bleeding and traumatized after being raped by an acquaintance, the 18-year-old valedictorian gathered clumps of her ripped-out hair and gripped it tightly, barely able to comprehend what had just occurred. Then one question jolted her from the fog: What if, in addition to everything else she had just endured, her rapist had impregnated her?" (AP Wire, 2007)

Emergency Contraception (EC) is a critical component of compassionate care for patients who have experienced sexual violence. For some patients, EC can help restore a sense of control following a truly violating trauma. As such, offering and providing EC to sexual assault patients is often an essential, empowering aspect of acute medical care.

The first documented case of doctors prescribing hormonal EC to sexual assault patients was published in the 1960s. By the late 1990s, additional research firmly established hormonal EC as a safe and effective regimen (Kaiser Family Foundation, 1997). Such research inspired well-organized advocacy to ensure that the Food and Drug Administration (FDA) approved a product for the purpose of emergency contraception. Prior to this time, EC was available only through "off-label" use of oral contraceptive pills. Off-label use of approved medications is a common and legal practice, and some hospital emergency rooms were providing sexual assault patients with emergency contraception in this way. However, lack of a FDA product specifically marketed as hormonal EC was seen as a barrier to EC becoming part of universal best care.

Largely as the result of a citizen petition filed with the FDA by the Center for Reproductive Law and Policy on behalf of a coalition of leading medical and public health groups, in September 1998, the Food and Drug Administration (FDA) approved the PREVEN™ Emergency Contraceptive Kit (PPFA, 2003; FDA, 1998). Preven packaged the Yuzpe hormonal regimen (four tablets containing ethinyl estradiol 0.05 mg and levonorgestrel 0.25 mg) with a home pregnancy test kit.

In 1999, the Food and Drug Administration (FDA) approved Plan B, the first progestin-only emergency contraceptive product. Close to the same time the FDA approved Plan B, a World Health Organization-supported study concluded that the

Plan B regimen is more effective and has fewer side effects than the Yuzpe method of emergency contraception (Task Force on Postovulatory Methods of Fertility Regulation, 1998).

Development, FDA approval, and marketing of Plan B contributed to increased efforts by sexual assault victim advocates to ensure that all sexual assault patients in New York City and in the state were offered and provided with emergency contraception when they sought acute medical care. Advocates successfully lobbied the Office of the New York State State Comptroller (OSC) by exposing the economic cost associated with unintended pregnancy following sexual assault. A study published in the International Journal of Fertility and Women's Medicine found that 1-5% of sexual assaults result in pregnancy (Patel et al., 2004). With heightened awareness of the cost of unintended pregnancy resulting from sexual assault, in 2003 the OSC issued a report stating that increased access to EC could save New York State \$450 million in one year (OSC, 2003).

On the heels of that report, the New York City Council passed three bills to provide women expanded access to emergency contraception. This legislation 1) made EC available at all New York City Department of Health and Mental Hygiene (DOHMH) operated health care facilities; 2) required pharmacies in NYC to post signs about the availability of EC; and 3) required hospitals to give rape survivors information about EC (NY City Council, 2006b). However, it was not until 2005 that the state passed Public Health Law 2805, which required all emergency rooms to provide information about EC and dispense it upon request (NYS DOH, 2005).

On August 24, 2006, the FDA approved Plan B for sale without a prescription to individuals 18 years and older. In December of 2006, EC became available in New York pharmacies. Effective February 1, 2007, Medicaid will cover Plan B for women without a prescription in New York (Pharmacy Access Partnership, 2007). This is a progressive state policy that will help ensure that all women, including survivors of sexual violence who do not access emergency medical care, have expanded access to EC.

Adult versus Child Protocols

The medical and forensic needs of child sexual abuse patients are distinct from those of adult sexual assault patients. As such, in 1996 the New York state departments of health and social services developed the *Child and Adolescent Sexual Offense Protocol* (OTDA, 1996). This protocol, now under revision, guides clinicians to provide best care and evidence collection for child sexual abuse. However, though the revised edition is not yet public, the currently circulated protocol does not prescribe guidelines to help clinicians determine when to use the child/adolescent versus adult protocol. In other words, the protocol does not prescribe an age cut-off for the either of the protocols. Instead, the protocols leave room for clinician discretion when choosing the most appropriate protocol. Similarly, the *New York State Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* does not indicate an age cutoff for using the adult protocol, as the authors recognize that the age at which the adult protocol is appropriate often depends on the circumstances in the case. For example, an 11-year post-pubertal female who is sexually assaulted by her boyfriend in many ways is better served by exam and evidence collection described in the *Adult* protocol. However, if that same child revealed at age 11 that she was being assaulted by her uncle, and that this sexual abuse had been occurring for several months, then the exam and evidence collection described in the *Child/Adolescent* protocol

would likely be more appropriate (though this determination remains subjective).

For the purpose of this research project, respondents were asked two questions about how their ED determines when to follow the *Child and Adolescent Sexual Offense Protocol* versus the *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. Specifically, respondents were asked: what determines using the child or adult protocol for treating patients reporting a sexual assault; and if the ED has a minimum age for using the NYS adult protocol.

The majority of EDs (53.8%) use age to determine whether they use the child or adult protocol. Most (48.5%) reported that clinicians follow the adult protocol for patients 18 years and older, although there were a variety of responses ranging from 12 to 21 years of age. All the SAFE Centers of Excellence responded that they use the adult protocol for patients who are 13 years of age and older; some hospitals said they found it appropriate to follow the adult protocol for patients as young as twelve (Table 7). However, EDs without specialized sexual assault services overwhelmingly answered that they followed the adult protocol for patients 18 and older. Emergency departments in public hospitals tended to report following the adult protocol for younger patients, whereas those in private hospitals began using the adult protocol with older teens. Brooklyn and Manhattan both replied with a range of answers, but in Queens 88.9% reported 18 as the minimum age.

Table 6: Reported Minimum Ages for Using Adult Protocol for Sexual Assault Patients

	Total for all EDs (n=33)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=22)	Public Hospital EDs (n=10)	Private Hospital EDs (n= 23)
Minimum Age for Using Adult Protocol?					
12	15.2% (5/33)	36.4% (4/11)***	4.5% (1/22)	10% (1/10)*	17.4% (4/23)
13	27.3% (9/33)	63.6% (7/11)	9.1% (2/22)	60% (6/10)	13.0% (3/23)
17	6.1% (2/33)	—	9.1% (2/22)	—	8.7% (2/23)
18	48.5% (16/33)	—	72.7% (16/22)	30% (3/10)	56.5% (13/23)
21	3% (1/33)	—	4.5% (1/22)	—	4.3% (1/23)

***p<.001 t-test between SAFE and non-SAFE, *p<.05 t-test between public and private

Other protocols

Two specific questions were asked about treating special populations of sexual assault patients: 1) does the ED have a specific protocol on how to obtain consent for a forensic exam from mentally retarded or developmentally disabled (MRDD) patients reporting a sexual assault, and 2) does the ED have a specific protocol on how to obtain consent for a forensic exam from patients reporting a sexual assault who are under the influence of drugs or alcohol.

Over half (56.4%) of the EDs surveyed reported specific protocols for treating patients with mental retardation/development disabilities (MRDD) who report a sexual assault. Those that did not stated that they had no *specific* protocols for sexual assault but general ones for working with MRDD patients. Fifty-one percent of the EDs responded that they had specific protocols in place for treating a patient who is under the influence of drugs or alcohol while reporting a sexual assault.

Emergency Contraception

All of the EDs in the sample reported routinely providing sexual assault patients with emergency contraception. Nearly all (92.3%) of the EDs reported that the emergency contraception is obtained directly from the health staff in the emergency department. In addition, all of the EDs also reported giving the patient a pregnancy test (if they were not already pregnant).

Sexually Transmitted Infections (STIs)

Providing Prophylaxis

It is considered best care to provide prophylaxis (preventive medicine) for sexual assault survivors to prevent sexually transmitted infections from occurring as a result of the assault. Clinicians should offer (and, with the patient's consent, provide) sexual assault patients prophylaxis for HIV, gonorrhea, Chlamydia, hepatitis B (if not vaccinated) and trichomonas/bacterial vaginosis. Though not a sexually transmitted infection, clinicians should also offer patients prophylaxis for tetanus when appropriate.

Patients are provided with HIV post-exposure prophylaxis, also called HIV PEP, in 100% of the SAFE Centers of Excellence and 97.4% of non-SAFE EDS. All private EDs routinely provide HIV PEP, compared to 90% of public EDs surveyed. Most of the non-SAFE Eds (92.8%) routinely provide prophylaxis to sexual assault patients for STIs, compared to 100% of SAFE Centers of Excellence. All public EDs, compared to 93.1% of private, offer prophylaxis.

STI Testing

There is a current national debate about whether to test patients for STIs. One of the major issues in this debate is whether the test results can be brought up in court since they could prove that an STI was present *prior* to the sexual assault. Another reason cited for not testing is the difficulty following up with sexual assault patients should their STI tests come back positive. Furthermore, many programs do not conduct rapid HIV tests because the trauma related to the assault makes it difficult to do voluntary counseling and testing (VCT) in the emergency department. Patients are always offered prophylaxis and follow-up baseline testing within the next several days.

Advocates in favor of testing for STIs argue that the role of SAFE clinicians is to provide as much information as possible to law enforcement so that if the case goes to trial, the jury has as much evidence as possible. They also argue that sometimes evidence collection occurs after the incubation period of an STI and that some STIs, like trichomoniasis, can be found immediately after sexual intercourse and could be linked to the perpetrator.

The *NYS Protocol for Acute Care of the Adult Patient Reporting a Sexual Assault* states:

“routine testing for gonorrhea, Chlamydia and syphilis is *not* recommended. In general, testing for sexually transmissible diseases at the time of initial exam usually ascertains a patient had an STD before the assault. Prior exposure to a sexually transmissible disease can be used to bias a

jury against a patient in court. All patients are given medication, as if infected, so testing a patient does not change the course of treatment. Examiners must inform patients of the possible risks of contracting a sexually transmissible disease, and provide them the information with which to make informed decisions regarding testing and treatment: *antibiotic prophylaxis is standard care*” (emphasis added, NYS DOH, 2004).

Furthermore, the NYS protocol elaborates on the testing for HIV, hepatitis B and hepatitis C by saying:

“HIV, hepatitis B, and hepatitis C can be serious and life-threatening consequences of exposure to blood and/or body fluids of a carrier. The patient must be offered testing for HIV, hepatitis B, and hepatitis C at the time of the health care and evidentiary exam.” Lastly, the

protocol states, “Trichomonas and bacterial vaginosis can be diagnosed or ruled out by a wet prep done in the emergency department, and treatment provided if positive” (NYS DOH, 2004).

Table 7 illustrates whether sexual assault patients are tested for STIs in the ED and for which STIs cultures are taken. A little over half (66.6%) of respondents reported testing for STIs. Of those, nearly all test for gonorrhea and Chlamydia (92.3% and 96.2% respectively). A much smaller percentage of respondents reported testing for hepatitis C, conducting a rapid HIV test or a wet prep for either trichomonas and/or bacterial vaginosis (15.4%, 19.2% and 19.2% respectively). Furthermore, the majority (89.7%) of EDs reported providing the patient with prophylaxis for STIs.

A much smaller percentage of the SAFE Centers of Excellence tested for STIs than non-SAFE EDs (36.4% vs. 78.5%). Among the four SAFE Centers of

Table 7: Testing for STIs by Hospital ED Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Do you test for STI's? Yes I don't know	66.6% [26/39] —	36.4% [4/11] —	78.5% [22/28] 3.5% [1/28]	50% [5/10] —	72.4% [21/29] 3.4% [1/29]
Test for Hep B	38.5% [10/26]	25% [1/4]	40.9% [9/22]	40% [2/5]	38.1% [8/21]
Hep C	15.4% [4/26]	25% [1/4]	13.6% [3/22]	40% [2/5]	9.5% [2/21]
Gonorrhea	92.3% [24/26]	100% [4/4]	90.9% [20/22]	80% [4/5]	95.2% [20/21]
Chlamydia	96.2% [25/26]	100% [4/4]	95.4% [21/22]	80% [4/5]	100% [21/21]
Syphilis	53.8% [14/26]	25% [1/4]	59.1% [13/22]	40% [2/5]	57.1% [12/21]
Rapid HIV Testing	19.2% [5/26]	0	22.7% [5/22]	0	23.8% [5/21]
Trichomonas and/or Bacterial Vaginosis	19.2% [5/26]	75% [3/4]	9.1% [2/22]	40% [2/5]	14.3% [3/21]

Excellence that do test for STIs (36.4%), all test for gonorrhea and Chlamydia, and one tests for hep B, hep C and syphilis. A much larger percentage (78.5%) of non-SAFE EDs routinely test for STIs. Of these, 90.9% test for gonorrhea, 95.4% test for Chlamydia, and only 13.6% test for Hep C. Half (50%) of the public EDs surveyed, and nearly three-quarters (72.4%) of the private EDs test for STIs. None of the public EDs surveyed conduct rapid HIV testing compared to nearly a quarter (23.8%) of private EDs.

Safe Discharge

It is important to ensure the safety of patients reporting a sexual assault. Appropriate and safe discharge was measured with five indicators: 1) discharge destination inquiries, 2) allowance of overnight stays for sexual assault patients because of safety concerns, 3) provision of transportation for sexual assault patients leaving the ED, 4) availability of replacement clothing, and 5) routine follow-up outreach to sexual assault patients the next day.

The *NYS Protocol for Acute Care of the Adult Patient Reporting Sexual Assault* states that the “hospital must provide each patient with an appropriate and safe discharge, including: medical transfer as necessary, necessary and appropriate follow-up care/referrals, hospital contact person to assist with release or disposal of sexual offense evidence, suitable attire, and transportation or appropriate arrangement as necessary to meet patient needs” (NYS DOH, 2004).

Furthermore, for SAFE Centers of Excellence, the emergency department must report to the NYS DOH that “safe discharge is assured for the patient” (NYS DOH, 2004).

Most EDs surveyed (84.6%) always inquire about the victim’s discharge destination, and none reported never asking. Furthermore, all EDs allow an overnight stay until the patient can secure a safe location. All SAFE Centers of Excellence reported ‘always’ inquiring about a victim’s discharge destination, compared to 78.5% of non-SAFE EDs. All of the public hospitals also ‘always’ inquire, compared to 79.3% of private hospitals.

Most of the EDs surveyed (76.9%) reported routinely securing transportation home for patients reporting a sexual assault. All of the public hospitals routinely secure transportation, compared to 69% of private EDs. The majority of SAFE Centers of Excellence (91%), and non-SAFE EDs 74% do so, as well.

Often the clothing that a sexual assault patient wears into the ED is retained for evidence. We asked how often replacement clothing was made available to sexual assault patients. All of the SAFE Centers of Excellence reported having replacement clothing ‘always’ (81.8%) or ‘most of the time’ (18.2%) for patients. Among non-SAFE EDs, half (50%) reported ‘always’ having replacement clothing available, 32.1% reported having clothing ‘most of the time,’ 14.2% reported ‘sometimes’ and one ED reported ‘never’ having replacement clothing available. Similar proportions of public and private EDs reported always having replacement clothing: 60% of public EDs and 58.6% of private EDs.

A smaller percentage (64.1%) follow up the next day to ensure the patient’s safety after discharge. Nearly all of the SAFE Centers of Excellence (91%) followed up with the patient the next day to ensure their safety, compared to 53.5% of non-SAFE EDs. Eighty percent of the public EDs and a little more than half (58.6%) of the private EDs followed up with the patient the following day ($p < .05$). Again, Brooklyn (72.7%) and Manhattan (77%) were similar in the percentages of surveyed EDs that followed up with patients. Many respondents mentioned that if the emergency department did follow-up, it was the social worker’s responsibility.

Chapter 3: Forensic Evidence Collection

An important component in helping a sexual assault case in the criminal justice process is in the collection of DNA evidence during a sexual assault exam. DNA has become an essential element when trying to match an offender to a crime.

In 2006, the statute of limitations for rape cases was lifted in New York. In September 2002, Congress passed a law to assess the backlog of DNA analysis of rape kit samples and to improve investigation and prosecution of sexual assault cases with DNA evidence (Library of Congress, 2002). In October 2004, Congress passed the Justice For All Act, which provides funds to assess DNA backlogs, to enhance DNA laboratories, and to help laboratories comply with Federal code.

When a sexual assault victim enters a NYS hospital, it must follow state guidelines on how to treat the patient, including gathering forensic evidence, if the patient decides to report the crime. The New York State Department of Health, in conjunction with the New York State Division of Criminal Justice Services (DCJS) and the state crime labs developed a Sexual Offense Evidence Collection Kit. While most materials/supplies used in collection of forensic evidence are routinely found in hospital emergency departments, the use of a standardized kit provides the following benefits:

- Standardization of evidence collection procedures across the state;
- At the time of crisis/need, everything needed to perform the exam is “in the box;”
- The knowledge is current and applicable to any hospital in New York State; and
- Standardization of procedures and materials in evidence collection yields better outcomes for survivors in court (NYS DOH, 2004).

Kits are provided by the New York State Division of Criminal Justice Services at no cost to hospitals in the state. If the assault occurred within 96 hours, an evidence collection kit should be used. The kit

includes instructions on how to collect forensic data, including how to collect hair samples, swab samples, and how to close and store evidence.

If a patient was under the influence of drugs during the assault, the examiner can decide to use a Drug Facilitated Sexual Assault Evidence Collection Kit. This kit includes the collection of blood and urine samples from the patient.

Since physical evidence is short-lived, forensic photography can also document injuries. If the patient consents, the examiner will photograph the injuries, using a scale for measurement reference, to show the court the extent of the injuries at the time of the exam. Photographs offer an accurate record of the injuries for the court and jury.

Collecting forensic data and maintaining the chain of evidence collection is crucial to each criminal justice case. A hospital is required to follow NYS protocols to help sustain the integrity of the data. Any violation can result in the evidence being inadmissible in court. According to the Department of Health’s *NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, a hospital’s protocol should include the following:

- During the patient consent process, a patient should understand the importance of forensic data collection;
- A patient must consent to the use of the NYS Sexual Offense Evidence Collection Kit, so that data can be collected;
- A patient must consent to the use of photography for the purpose of collecting forensic evidence;
- Photographs must be documented with the date and the signature of who took the photographs;
- Photographs must be placed and recorded properly with the chart, following all appropriate procedures;

- If necessary, photographs must be developed following all appropriate procedures;
- To maintain the chain of evidence, each specimen collected during an exam must be accounted for, sealed appropriately, and can never be left alone with a patient. A patient, a patient's family member, or an advocate cannot transport the evidence, as it can only be transported by the examiner;
- The hospital must seek consent to store the evidence collected or hand it over to law enforcement;
- If the patient has agreed to the data collection but not reporting the incident to the police, the hospital must store the Sexual Assault Evidence Collection Kit at least thirty days in locked storage;
- If the Drug-Facilitated Sexual Assault Evidence Collection Kit is used, then the hospital must store this at least thirty days in locked, refrigerated storage;
- After thirty days, if the patient does not want to report the incident to the police, the hospital can discard the evidence;
- The hospital is required to hire someone to coordinate the hospital procedures and storage, law enforcement and forensic laboratories (NYS DOH, 2004).

NYS Sexual Offense Evidence Collection Kit

There are ten steps to follow in the NYS Sexual Offense Evidence Collection Kit:

1. Obtaining oral swabs and smears;
2. Obtaining trace evidence by having the patient undress over a sheet of white paper to collect any hairs or other evidence;
3. Step 3 includes examining clothing and underwear using a Wood's lamp and collecting and packaging clothing that may contain evidence;
4. Step 4 involves collecting debris from the patient's body;
5. Step 5 includes examining dried secretions of blood or semen and/or bite marks including matted material on pubic or head hair and taking swabs as needed;
6. Step 6 involves taking fingernail scrapings;
7. Step 7 includes pulling head hairs;
8. Step 8 involves combing the pubic hair so that any loose hairs or debris will fall onto the white paper;
9. Step 9 includes pulling pubic hairs, if needed, and conducting the external genital exam and finally,
10. Step 10 involves collecting anal swabs and smears.

We collected information on ten indicators related to use of evidence collection kits: 1) if the ED uses the NYS Sexual Offense Evidence Collection Kit; 2) if the examiners follow all the steps listed in this kit, and if not, which steps do they not follow and why; 3) if the ED uses the NYS Drug-Facilitated Sexual Assault (DFSA) Kit; 4) if the examiners follow all the steps listed in the kit; 5) if the ED has the capacity to store kits in locked storage and keep DFSA kits refrigerated as well; 6) if the ED keeps a record log for the release of forensic evidence to law enforcement; 7) on average, how long they can store forensic evidence kits; and 8) if the ED contacts victims prior to throwing away kits.

Nearly all hospitals surveyed (94.9%) use the NYS Sexual Offense Evidence Collection Kit, with one ED Director stating the hospital does not use the kit and one who did not know if the standardized kit was used. The majority (71.8%) routinely follow all the steps listed in the kit, when applicable.

However, 11 ED Directors, including seven at SAFE Centers of Excellence, stated that they did not follow all the steps in the kit. All of those who did not follow the steps in the kit reported that they did not pull head or pubic hairs. This is in accordance with the NYS DOH Protocol, which states,

"it is recommended that pubic hair standards **not** be pulled during the initial medical exam. They can be pulled at a later date (if the pros-

ecution requests these samples and the victim consents to the procedure)” (emphasis original, NYS DOH, 2004).

The Protocol also goes on to state that

“pulled hair standards for evidence collection are considered by many to be very traumatic to the victims of sexual assault. The examiner must use his/her professional judgment regarding whether or not to complete this step, based upon the physical and/or emotional well-being and preference of the victim. Hairs can be pulled at a later date, if needed” (NYS DOH, 2004, p. 36).

Drug Facilitated Sexual Assault Kits

There has been an increase in the involuntary administration of some drugs, such as gamma hydroxybutyrate [GHB], Ketamine, flunitrazepam (Rohypnol), and Benadryl often in the presence of alcohol to render a person incapacitated and more susceptible to sexual assault. Many of these drugs are available over-the-counter. The use of these drugs results in a loss of consciousness, memory loss and incapacitation. The result is that many victims of drug-facilitated sexual assault may not remember the assault itself (NYS DOH, 2004).

In November 2003, the New York State Division of Criminal Justice Services (NYS DCJS) announced the availability of a standardized Drug Facilitated Sexual Assault (DFSA) evidence collection kit. The kits are provided free to hospitals in New York State and should be used only in cases where there is a suspicion of drug-facilitated sexual assault. The collection can be done up to 96 hours after the ingestion of the suspected drug, as many drugs will stay in the body’s system for up to four days. As with all forensic evidence collection, permission must be obtained from the patient.

The NYS Protocol stresses that the examiner should assess the possibility of a drug-facilitated assault. Hospitals are given a drug-facilitated sexual assault alert sheet that highlights the signs that determine if a sexual assault may have been drug-facilitated including: memory loss, confusion,

impaired motor skills, reduced inhibition, dizziness, drowsiness, impaired judgment, and/or intoxication disproportionate to the amount of alcohol consumed (NYS DOH, 2004).

Drug Facilitated Sexual Assault (DFSA) Evidence Collection Kits are used by 84.6% of the hospitals, when necessary. However, four emergency departments reported not using the standardized DFSA kit, and two EDs reported that they did not know if they used the standardized DFSA kit; all six were non-SAFE sites.

Specialized Equipment and Injury Documentation

Injury documentation is an important component of both medical treatment and forensic evidence collection. Oftentimes, injury documentation and forensic evidence collection is enhanced with specialized equipment. We measured the following indicators of injury documentation and specialized equipment: 1) if the ED has a dedicated colposcope, a magnification tool to find genital injuries, to use for patients reporting a sexual assault and whether or not it can photo-document; 2) if the ED has swab dryers; 3) if the ED has an ultraviolet light or Wood’s lamp; 4) if there is a standard procedure for photo documentation; 5) if the ED has a camera to photograph injuries and what type; 6) if the ED uses a ruler or scale as measurement reference for injury documentation in photos; 7) if the program routinely labels photos with the patient name or ID number and date; 8) if the ED uses Toluidine blue for injury detection; and 9) if the ED uses a standardized comprehensive care form (their own or from NYS DOH) to document evidence collection and injury.

Specialized equipment

Colposcopes

Specialized equipment is required to properly perform the forensic exam. However, most hospitals do not have such equipment.

Colposcopy is a diagnostic procedure in which a colposcope is used to examine an illuminated, magnified view of the cervix, the tissue of the vagina,

and vulva. The colposcope basically functions as a lighted binocular microscope, helping to identify possible injuries (see box for more information).

All of the SAFE Centers of Excellence have a dedicated colposcope to use only with sexual assault patients. However, only 28.6% non-SAFE EDs surveyed have a dedicated colposcope for use with sexual assault patients. A much larger proportion of public hospitals, as compared to private hospitals, have a dedicated colposcope (90% vs. 34.5%). Furthermore, the majority of surveyed EDs in Manhattan (64.3%) have a dedicated colposcope, compared to 45.5% in Brooklyn and 33.3% in Queens.

It is important for the colposcope to be able to photo-document. The majority of EDs with colposcopes have this capability.

Swab Dryers

The Sexual Offense Evidence Collection Kit requires the collection of several swabs. The swabs must be completely dry before being inserted into the evidence collection kit. Air-drying swabs take about an hour. Waiting for a number of swabs to air-dry can unnecessarily prolong a lengthy and uncomfortable exam. Swab dryers may reduce the exam's duration and ensure that swabs are thoroughly dry before being included in the evidence collection kit.

About three-quarters of SAFE Centers of Excellence (72.7%) reported having swab dryers, compared to only 10.7% of non-SAFE EDs. More than one quarter of the EDs in Brooklyn (27.3%) and Manhattan (28.6%) but only 11.1% in Queens have swab dryers.

Wood's Lamp

The Wood's lamp (WL) is a source of ultraviolet radiation emitting wavelengths of approximately 320 to 400 nm. The WL makes many substances fluorescent, including semen (Santucci, et al., 1999). It is small, relatively inexpensive, safe, and easy to use in the emergency department setting. Consequently, it is often an integral part of sexual assault evaluations (Santucci et al, 1999). Nearly all of the SAFE Centers of Excellence (90.9%) and two-thirds (67.8%) of non-SAFE EDs have a WL or ultraviolet light to detect semen on clothing and the body that is otherwise invisible to the naked eye. Nine of 10 public EDs surveyed (90%) have a WL, compared to 71% of private hospitals. The proportion of EDs in Brooklyn (81.8%) and in Manhattan (85.7%) with the lamps is much higher than in Queens (33.3%).

Photo documentation

When injuries are found during a sexual assault physical examination, they should be photographed in addition to written descriptions and body diagrams. This is important for both genital and non-genital injuries. According to the NYS DOH Protocol, "external genital injuries may be photographed using the same techniques as non-genital injuries or using a colposcope with photographic capability, whereas vaginal, cervical, and anal injuries will require use of a colposcope and/or anoscope with photographic capability" (NYS DOH, 2004).

The NYS DOH protocol also highlights the importance of photography in the acute care setting:

Magnification for Injury Detection: The Use of Colposcopy with Sexual Assault Patients

A colposcope is a piece of medical equipment that magnifies genital tissue. In the context of the sexual assault exam, it enhances identification of genital trauma. A colposcope is a binocular system with a built-in light source that consists of magnifying lenses of varying strength. Colposcopes are usually mounted on a stand, and most models have adapters so that cameras or video equipment can be attached to capture images. Such photo evidence can prove useful in prosecution of sexual assault

cases. Moreover, if the images can be viewed via a video monitor, the patient has the option of viewing the examination if s/he so wishes. A video monitor also provides the examiner with an opportunity to maneuver based on what they see on the monitor rather than through the bifocal lenses.

The colposcope allows examiners to view microscopic lacerations and injuries not apparent to the naked eye. In a California study of 131 patients

Magnification (*continued*)

who were raped and seen at the hospital within 48 hours, the use of a colposcope found that 114, or 87%, had positive findings of injury (Slaughter & Brown, 1992). In a study comparing the finding of injuries by colposcope versus visualization alone, researchers found that the colposcope improved detection of genital trauma in adult female sexual assault victims, as compared with a visual examination alone at a statistically significant level (Lena-han, Ernst & Johnson, 1998).

There are many advantages to utilizing a colposcope in sexual assault examinations:

- Colposcopy is a non-invasive technique that can improve injury detection with minimal discomfort for the survivor.
- The enhanced lighting and magnification provided by colposcopy improve both the medical and forensic examination.
- Photographs of injuries detected by colposcopy are useful evidence and good tools for teaching about genital injury, forensic photography and documentation (Templeton & Williams, 2006).

Review and interpretation of colposcopic images, however, is a trained skill. This is underscored by a 1994 study conducted to determine the agreement between examiners on findings represented by colposcopic images. Medical interns were asked to interpret colposcopic photographs without any specific training. The study found that the interns' interpretations were only slightly better than the random chance of accurate and inaccurate judgments (Braydon, 1994 as cited in Templeton & Williams, 2006).

Until recently, no studies had examined whether detection of microscopic genital injury in adult sexual assault patients is consistent with the experience of sexual assault. In other words, few studies have been conducted examining the presence of microscopic genital injury following consensual versus forced sex. However, a recent study conducted by Anderson and colleagues (2006) found no statistical difference in the presence of injury between consensual and nonconsensual groups of patients. This study included a prospective group of 46 women who were examined within 24 hours of having consensual sex and a retrospective chart review of 56 women over a one-year period who presented at the emergency department following a reported sexual assault (Anderson, McClain &

Riviello, 2006). Despite these findings, there was a statistically significant group difference in the injuries to the labia minora found only among subjects in the nonconsensual group (Anderson, McClain & Riviello, 2006). The authors concluded that these findings reinforce the importance of a thorough, careful genital examination of both the internal and external genitalia as part of the standardized sexual assault exam.

While the majority of research on colposcopy in the context of sexual assault focuses on the forensic utility of enhanced visualization of genital injury, one recent study actually focused on the mental health impact colposcopy can have on sexual assault patients. This study, conducted by Mears and colleagues (2003), involved girls aged 11 to 18 years who had been referred to a medical center for evaluation and treatment of sexual abuse. Before examining the patients in the study, clinicians conducted several pre-exam evaluations to determine the level of anticipation, anxiety and stress these girls were experiencing. Then, before the exam, each girl was engaged in a standardized educational session in which she learned about genital anatomy, discussed abuse issues and learned information about sexually transmitted infections. After that, clinicians carried out a medical and forensic exam that included video colposcopy. Seventy-nine percent of the girls chose to watch the colposcopic exam on video while it was being performed. The study found that there was a significant reduction in anxiety from pre-examination to post-examination, and the patient's feelings about the medical exam were significantly more positive following the exam. (Mears, Heflin, Finkel, Deblinger & Steer, 2003).

Finally, there is some debate currently in the New York City about whether a medscope (adapted from dental practice) might be a more useful tool for sexual assault forensic exams as compared to the colposcope. Some studies report that the medscope has a greater depth of field than the colposcope, and is easier to use to document injuries on other parts of the body. It is also easier to operate and requires less skill than the colposcope. However, colposcope manufacturers are also designing new instruments tailored to forensic use for "the highest quality of photo documentation, evidence preservation and the usefulness of the images for trial" (Little, 2001, p13). Programs in New York City are exploring both these technologies to maximize photodocumentation of genital injury in sexual assault patients. (Rape Crisis Network Europe, 2003)

1. Much physical evidence is short-lived, and, if not recorded, may be lost.
2. The appearance of injuries can change significantly with time.
3. Photographs create a permanent record of the acute injury and reduce subjectivity.
4. Photographs serve as an aid to memory.
5. They permit the court and jurors to see the evidence “as it was” (NYS DOH, 2004).

According to the protocol,

“conventional 35mm cameras are preferred for legal work, and 35mm film (ISO 100 or 200) for slides are preferred. These cameras allow the use of interchangeable lenses (e.g., macro) and flashes (e.g., ring flashes), which produce better results for close-up work. The image quality cannot be viewed until a later date because of film development. Many hospitals do not have access to police or other secure photo labs, and patient confidentiality and the chain of custody preclude commercial photo shops from handling such material” (NYS DOH, 2004).

The NYS DOH Protocol suggests contacting local criminal justice agencies on the use of digital cameras:

“although digital cameras are widely available, they have not yet been ‘fully tried and tested’ in the legal arena. Prior to a decision regarding whether to use digital photography, seek guidance from the local District Attorney and courts as to the admissibility of digital photographs as evidence in a particular jurisdiction” (NYS DOH, 2004).

The protocol goes on to state that “instant” cameras, such as Polaroid, are commonly found in emergency departments and clinics where victims are examined. These cameras allow the image to be viewed immediately, and eliminate concerns about developing images outside the facility.

The image quality and color reproduction tends to be less reliable than conventional cameras. Most colposcopes can use either Polaroid-type or 35mm cameras (NYS DOH, 2004).

In this study, all of the hospitals surveyed use cameras to photograph injuries. Many EDs use Polaroid cameras (41%), and 20.5% use digital cameras. Approximately 38.5% use more than one type, either Polaroid, digital, or 35mm. Among hospital emergency departments that use digital cameras, 100% are private hospitals, and half (50%) are SAFE Centers of Excellence. The majority of the hospital EDs using digital cameras exclusively are located in Manhattan (62.5%).

Nearly all hospitals (97.4%) routinely label photographs, and 89.7% have a standard procedure for photo documentation. All four hospitals without a standard procedure in place for photo documentation, all are non-SAFE EDs. The majority of surveyed hospital EDs (69.2%) use a ruler or scale in the photo for reference.

Toluidine Blue for Injury Detection

In the context of a sexual assault forensic examination, the dye Toluidine blue is used to locate and document injuries. Because the dye is selectively taken up by injured tissue, micro abrasions and lacerations can be visualized after the genital and perianal area are stained with Toluidine blue and then destained. Any remaining blue after destaining is indicative of cellular damage. The use of Toluidine blue dye is controversial in some jurisdictions (e.g., it may be perceived by the court as changing the appearance of the tissue) and not universally used. Only three of the EDs surveyed (7.7%) use Toluidine blue to illustrate abrasions and other injuries: two SAFE Centers of Excellence and one non-SAFE ED.

Injury Documentation

The *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* includes a Comprehensive Sexual Assault Assessment Form in the Appendix (NYS DOH, 2004). This three-page form includes sections on the initial assessment, pertinent past medical history, sexual assault history, physical examination, examination techniques, diagnostic tests, STI prophylaxis, HIV PEP, post-coital contraception, referrals given and chain of custody and ends with the provider's signature. This form is a blueprint for all the information that should be recorded during a sexual assault exam.

All 39 hospitals use a comprehensive care form to document evidence collection and the forensic exam. The majority of hospital EDs (71.8%) use the NYS DOH Comprehensive Sexual Assault Assessment Form included in the Protocol; 25.6% use a form developed by their hospital for the assessment; and one ED uses both. The majority (81.5%) of non-SAFE EDs use the form available in the NYS DOH Protocol, whereas only 45.5% of SAFE Centers of Excellence use the NYS DOH comprehensive form. The majority of EDs that use the NYS DOH form are private EDs (82.8%); 60% of public EDs use their own form.

Evidence Storage

All of the EDs surveyed have the capacity to store the NYS Sexual Offense Evidence Collection Kits in locked cabinets. Nearly all (89.7%) store the kits within the hospital, while 10.3% (4 EDs) turn the kits over to law enforcement immediately. It is unclear whether these four emergency departments are obtaining patient consent prior to doing so. In New York, a patient may consent to having evidence collected and *not* consent to reporting the crime.

When this happens, the kits should be securely stored at the hospital and turned over to the police *only* when the patient consents to release of the kit thereby involving law enforcement.

Due to survey limitations, we were unable to follow-up about why certain programs reported not storing kits. Further research should explore this finding.

Similarly, if the DFSA kit is not immediately handed over to a police officer for transport to the NY Crime Lab, the sealed kit must be placed in a secure and refrigerated area to maintain the quality of the blood and urine samples taken. In this sample, 79.4% of EDs have the capacity to store DFSA kits in refrigerated secure storage. Four SAFE Centers of Excellence and two non-SAFE EDs were unable to securely store DFSA kits in refrigerated areas.

NYS law requires that hospitals store the NYS Sexual Offense Evidence Collection Kits for at least 30 days. Among hospitals surveyed, only four non-SAFE hospitals (11.4%) stored kits less than 30 days, and three non-SAFE EDs (8.6%) did not know how long they were stored. The rest of the hospitals stored the kits at least 30 days, with 37.1% storing them for one to three months. Table 8 details how long, on average, the surveyed hospital EDs store Sexual Offense Evidence Collection Kits and how many notify victims prior to throwing kits away in addition to other variables. Only eight of the surveyed hospitals notify the victim prior to discarding the kits, four SAFE Centers of Excellence and four non-SAFE hospitals.

Table 8: Storage of NYS Sexual Offense Evidence Collection Kits, Chain of Evidence and Patient Notification

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Use NYS Collection kit? <i>Yes</i> <i>I don't know</i>	94.9% (37/39) 2.6% (1/39)	100% (11/11) —	92.8% (26/28) 3.5% (1/28)	100% (10/10) —	93.1% (27/29) 3.4% (1/29)
Use the NYS DFSFA kit? <i>Yes</i> <i>I don't know</i>	84.6% (33/39) 5.1% (2/39)	100% (11/11) —	78.5% (22/28) 7.1% (2/28)	100% (10/10)* —	79.3% (23/29) 6.9% (2/29)
Capacity to store DFSFA kits? <i>Yes</i> <i>I don't know</i>	79.4% (27/34) 2.9% (1/34)	60% (6/10) —	87.5% (21/24) 4.1% (1/24)	100% (10/10)* —	72% (18/25) 4% (1/25)
Record log of release <i>Yes</i> <i>I don't know</i>	86.8% (33/38) 2.6% (1/38)	100% (11/11) —	81.5% (22/27) 3.7% (1/27)	90% (9/10) —	85.7% (24/28) 3.6% (1/28)
Store evidence kits? <i>Store kits</i> <i>Turn over to police</i>	89.7% (35/39) 10.3% (4/39)	100% (11/11) —	85.7% (24/28) 14.2% (4/28)	100% —	86.2% (25/29) 13.8% (4/29)
How long store kits? <i>Less than 1 month</i> <i>1–3 months</i> <i>4–6 months</i> <i>7–12 months</i> <i>1–5 years</i> <i>I don't know</i>	11.4% (4/35) 37.1% (13/35) 25.7% (9/35) 2.9% (1/35) 14.3% (5/35) 8.6% (3/35)	— 9.1% (1/11) 45.5% (5/11) 9.1% (1/11) 36.4% (4/11) —	16.6% (4/28) 50% (12/24) 16.6% (4/24) — 4.1% (1/24) 12.5% (3/24)	— 30% (3/10) 30% (3/10) 10% (1/10) 20% (2/10) 10% (1/10)	16% (4/25) 40% (10/25) 24% (6/25) — 12% (3/25) 8% (2/25)
Contact victim prior to throwing away kits <i>Yes</i> <i>I don't know</i>	22.9% (8/35) 25.7% (9/35)	36.4% (4/11)** —	16.6% (4/24) 37.5% (9/24)	50% (5/10)* 20% (2/10)	12% (3/25) 28% (7/25)
Has anyone been trained to testify in court?	71.8% (28/39)	100% (11/11)	60.7% (17/28)	100% (10/10)**	62.1% (18/29)

* p<.05, ** p<.01 t-test run between SAFE and non-SAFE and between private and public EDs

Maintaining the Chain of Evidence

Accurately maintaining and accounting for sexual assault evidence is essential for the evidence to be useful in a court of law. The “chain of custody” is a legal term describing the movement, location, and succession of people responsible for the sexual assault evidence (NYS DOH, 2004). According to the NYS Protocol,

“in order to maintain the chain of custody, an evidence collection kit and the specimens it contains must be accounted for from the moment collection begins until the moment it is introduced in court as evidence. Each item of evidence must be labeled with the initials of everyone who handled it, the date, a description and source of the specimen, the name of the examiner, and the name of the patient. Evidence not included in the kit (e.g., clothing, photographs, etc.) must be individually packaged, sealed and labeled with a description of the item. Providers must have specific protocols in place to insure confidentiality and maintain the chain of custody of the evidence... Maintaining the chain of custody during the examination is the sole responsibility of the examiner, and requires no outside assistance” (NYS DOH, 2004).

In this study, most EDs (86.8%) keep a record log of all evidence that is turned over to law enforcement. As seen in Table 8, all of the SAFE Centers of Excellence maintain a record, whereas two non-SAFE EDs report that they do not have a record log that documents the release of forensic evidence to law enforcement. SAFE clinicians are often called upon to testify on the physical findings of an exam in a court of law. The majority of the hospitals surveyed (71.8%) have trained staff how to testify in court about medical evidence, including all of the SAFE Centers of Excellence.

Chapter 4: Information, Advocacy and Follow-up Care

Availability of Information

Providing written information to sexual assault patients in their native language is an important component of quality care. Research has shown that trauma impacts the way a person retains information. For sexual assault patients who have just experienced a very serious trauma, retaining complicated medical and other information may be difficult, which underlies the importance of having low-literacy written materials available.

To assess the availability of information we measured the availability of: 1) literature on follow-up counseling, 2) Crime Victims Board claim forms in the Emergency Department, 3) literature on emergency contraception, 4) literature on HIV/PEP, 5) literature on STIs, 6) information on reporting to the police and 7) all the above in languages other than English.

Follow-up Counseling and EC Literature

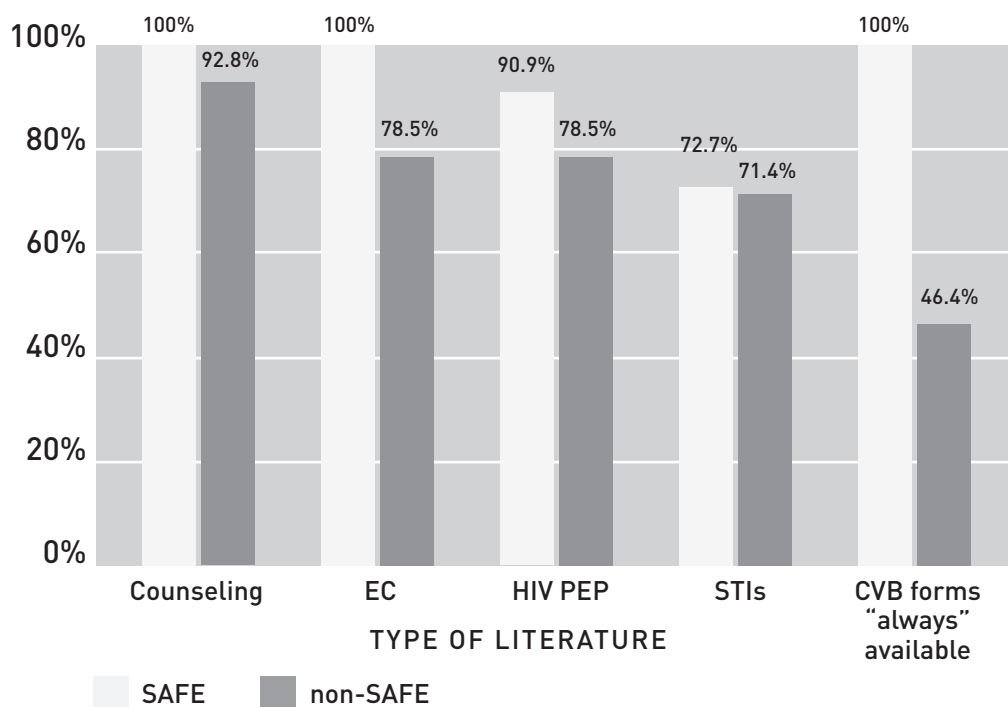
Most hospitals provided written information on follow-up counseling (94.9%) and have resources in languages other than English (81.1%), including all SAFE Centers of Excellence and all public hospitals. Of the emergency departments that provide this information in languages other than English, most EDs report offering it in Spanish (93.3%).

Emergency contraception literature is available in 84.6% of the EDs surveyed. This literature is available in all SAFE Centers of Excellence, in 78.5% of non-SAFE EDs, in 80% of public EDs and 86.2% of private EDs. Among EDs with this literature available, 78.8% report having it in languages other than English. Many of these EDs reported available literature in all the NYS DOH-published languages, including: Spanish, Chinese, Korean, Creole, Hindi, Arabic, and Russian.

Crime Victims Board Claim Forms

Crime Victims Board claim forms should also be available in the emergency department. The Forensic Repayment Act allows hospitals to be reimbursed up to \$800.00 for medical services provided to victims of sexual assault. Previously, victims of sexual assault were forced to pay their own medical expenses. The Forensic Repayment Act means that the victim does not have to apply to the Crime Victims Board (CVB) directly for a forensic exam. The CVB does offer compensation for other expenses incurred as a result of the crime to victims, and CVB claim forms should be available to patients in all EDs. A little more than half (61.5%) of the EDs reported having the Crime Victims Board claim forms available. When asked how often CVB forms are available, all of the SAFE Centers of Excellence reported 'always,' compared to only 46.4% of non-SAFE EDs (Chart 1). Twenty percent (21.4%) of non-SAFE EDs reported they did not know if the claim forms were available for sexual assault patients.

Figure 1: Availability of Literature for Sexual Assault Patients by Hospital ED Type



HIV PEP Information

Sexual assault patients who receive HIV post-exposure prophylaxis (PEP) also need written information on the treatment and follow-up. PEP is a 28-day treatment of combination antiretroviral drugs taken twice a day as a preventative measure against HIV infection after exposure. The efficacy of PEP has been widely debated, but its biological plausibility has been accepted based on scientific findings from data sources, such as case-controlled studies of occupational exposure, animals with exposure to the simian immunodeficiency virus (SIV), and mother-to-child transmission. Risk reduction was found from 25.1% to 9.3% [CDC, 2005].

If the patient has opted for the HIV PEP, the ED clinician would prescribe an HIV PEP starter kit, which will be given to the patient at the ED with further instructions to return for follow-up care. At the first follow-up visit, the patient will be offered HIV baseline testing. During follow-up visits, the patient will also be provided with the remaining doses of HIV PEP, or if they are HIV positive, with appropriate treatment. The follow-up care also includes subsequent HIV tests after the preliminary baseline HIV test, to check for any HIV infection from the assault. Providing information to the sexual assault patient in the ED is crucial given all the follow-up that needs to occur after the initial visit.

Most EDs surveyed (82.1%) provide literature about HIV PEP medications. As indicated in Chart 1, 90.9% of SAFE Centers of Excellence and 78.5% non-SAFE EDs provide written information on HIV PEP.

Furthermore, 70% of public hospital EDs surveyed and 86.2% of private hospital EDs provided this information. Among EDs that provide this information, 65.6% reported that it was also available in languages other than English. Of those that provide the information in languages other than English, the languages most frequently reported include Spanish (95.2%), Russian (28.5%) and Korean (23.8%).

It is also important to provide literature on other sexually transmitted infections (STIs), since the patient will either be tested and/or provided prophylaxis for many possible STIs. Nearly three-quarters of the EDs surveyed (71.8%) reported providing literature on STIs to sexual assault patients. As seen in Figure 1, SAFE Centers of Excellence and non-SAFE EDs almost equally provide this information (72.7% and 71.4%). Half of the public EDs reported providing this information, while 79.3% of private EDs make this information available to patients. Among EDs with this literature available, 72.4% reported providing it in other languages. All of these EDs report having the literature in Spanish and 19% in Russian.

All surveyed hospitals provide information to victims of sexual assault about police involvement.

Referral for Follow-up Care

We asked if the ED provided follow-up care services for sexual assault survivors: 1) follow-up appointments for HIV PEP; 2) referral to follow-up counseling at an in-house rape crisis program, an in-house social work program, a local rape crisis program, another program or a combination of these; 3) follow-up with patients regarding referrals and a timeframe; and 4) long-term follow-up care.

HIV PEP Follow-Up

When asked how often, on average, the staff in the emergency department makes a follow-up HIV PEP appointment for patients, 100% of SAFE Centers of Excellence reported 'always' doing so, compared to only 60.7% of non-SAFE EDs. Similarly, 100% of public hospital EDs, compared to 62.1% of private ones, make follow-up appointments for HIV PEP. Several EDs reported that they only provide the patient with the information for follow-up services. Others were unsure who made the appointment, and many suggested that the social work department usually makes those appointments.

Counseling Referrals

Table 10 shows the percentage of EDs surveyed that provided referrals for counseling and where the patients were referred. Overall, 94.9% of the EDs surveyed refer sexual assault patients for follow-up counseling. The majority of patients were referred to either an in-house rape crisis program (35.1%) or a local rape crisis program (29.7%). More of the public hospital EDs surveyed referred sexual assault patients to in-house social workers than private hospital EDs (30% vs. 14.8%).

Overall, 68.4% of the hospitals surveyed were able to routinely 'check in' with patients after discharge regarding their referrals. Most of the SAFE Centers of Excellence (90.9%) and 57.6% of non-SAFE EDs reported being able to check-in with patients. Of these hospitals, the majority (57.7%) call within 24 hours.

Table 9: Follow-up Care by Hospital ED Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospi- tal EDs (n=10)	Private Hospital EDs (n=29)
Refer patients for fol- low-up counseling	94.9% (37/39)	100% (11/11)	92.8% (26/28)	100%(10/10)	93.1% (27/29)
Where do you refer?					
<i>In-house rape crisis</i>	35.1% (13/37)	90.9% (10/11)***	11.5% (3/26)	50% (5/10)	29.6% (8/27)
<i>In-house social worker</i>	18.9% (7/37)	9.1% (1/11)	23.1% (6/26)	30% (3/10)	14.8% (4/27)
<i>Local rape crisis</i>	29.7% (11/37)	—	42.3% (11/26)	—	40.7%(11/27)
<i>Other</i>	8.1% (3/37)	—	11.5% (3/26)	10% (1/10)	7.4% (2/27)
<i>Combination</i>	8.1% (3/37)	—	11.5% (3/26)	10% (1/10)	7.4% (2/27)
Check-in with patients regarding their referrals	68.4% (26/38)	90.9% (10/11)	57.6% (15/26)	100%(10/10)**	59.3% (16/27)
If yes, how long after the patient leaves the ED do you check-in?					
<i>Within 24 hours</i>	57.7% (15/26)	60% (6/10)	56.2% (9/16)	60% (6/10)	56.3% (9/16)
<i>Within 48 hours</i>	19.2% (5/26)	30% (3/10)	12.5% (2/16)	20% (2/10)	18.8% (3/16)
<i>Within 1 week</i>	11.5% (3/26)	10% (1/10)	12.5% (2/16)	10% (1/10)	12.5% (2/16)
<i>I don't know</i>	11.5% (3/26)	—	18.7% (3/16)	10% (1/10)	12.5% (2/16)
Able to conduct long term follow-up?					
<i>Yes</i>	26.3% (10/38)	36.4% (4/11)	23.1% (6/26)	40% (4/10)**	21.4% (6/28)
<i>I don't know</i>	13.2% (5/38)	—	15.3% (4/26)	—	17.9% (5/28)

** p<.01, *** p<.001 t-test run between SAFE and non-SAFE and between private and public EDs

Very few (26.3%) of the EDs surveyed reported being able to conduct long-term follow-up with sexual assault patients. A larger percentage of SAFE Centers (36.4%) than of non-SAFE EDs (23.1%) reported being able to conduct long-term follow-up. Similarly, more public EDs (40%) reported being able to conduct long-term follow-up than private EDs (21.4%).

Victim Advocates

Once a sexual assault victim arrives at the hospital, best practice requires that a victim advocate be called. Research has clearly established that advocates are indispensable for victim-centered care (see box on Victim Advocates).

The most common type of victim advocates is a volunteer who works with local rape crisis programs and undergoes a mandatory, 40-hour training. Research demonstrates that volunteer rape victim

advocates improve survivors' satisfaction with the care they receive in the acute care setting at a statistically significant level (see the Alliance's companion study, *A Room of Our Own: Survivors Evaluate Services*). After training, advocates are on-call during specific time periods and report to the emergency department whenever a patient reporting a sexual assault arrives. In addition to volunteers, victim advocates may also be hospital social workers, other hospital staff or a combination of these.

According to the 2004 *National Protocol for Sexual Assault Medical Forensic Examinations*, services offered by volunteer advocates during the exam process may include:

- Accompanying the victims through each component, from the initial contact and the actual exam to discharge and follow-up appointments;
- Assisting in coordination of victim transportation from the exam site;
- Providing victims with crisis intervention and support to help cope with the trauma of the assault and begin the healing process;
- Actively listening to victims to assist in sorting through and identifying their feelings;
- Letting victims know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocating that victims' self-articulated needs be identified and their choices be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting victims to voice their concerns to relevant responders;
- Responding in a sensitive and appropriate manner to victims from different backgrounds and circumstances and advocating for the elimination of barriers to communication;
- Serving as an information resource for victims (e.g., answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of

medical and evidence collection procedures, explain legal aspects of the exam, help them understand their options in regard to treatment for STIs, HIV and pregnancy, and provide referrals);

- Providing replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aiding victims in identifying individuals who could support them during the healing process (e.g. family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers);
- Helping victims' families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support victims may need from them; and
- Assisting victims in planning for their safety and well-being.

To measure the services offered by victim advocates in EDs, we collected the following data: 1) the percentage of EDs that work with victim advocates to support sexual assault patients, 2) the type of victim advocates that are used, 3) the extent of victim advocate training, including the 40-hour rape crisis training, 4) how often, on average, the physical exam begins before the victim advocate is present, 5) the percentage of EDs that have an on-call schedule for victim advocates, and 6) the percentage of EDs that have a back-up, on-call schedule for victim advocates.

Types and Training of Advocates

As seen in Table 10, the majority of EDs surveyed use victim advocates to help support sexual assault survivors. About three in ten (31.4%) use only volunteer advocates. One-fifth (20%) only use hospital social workers or other hospital staff as their victim advocates.

Table 10: Types and Availability of Victim Advocates by Hospital ED Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
ED use victim advocates?	89.7% [35/39]	100% [11/11]	85.7% [24/28]	100% [10/10]**	86.2% [25/29]
What are these victim advocates?					
<i>Hospital SW</i>	17.1% [6/35]	9.1% [1/11]	20.8% [5/24]	10% [1/10]	20% [5/25]
<i>Other hospital staff</i>	2.9% [1/35]	9.1% [1/11]	—	10% [1/10]	—
<i>Volunteer advocates</i>	31.4% [11/35]	36.4% [4/11]	29.1% [7/24]	20% [2/10]	36% [9/25]
<i>Combination</i>	48.6% [17/35]	45.5% [5/11]	50% [12/24]	60% [6/10]	44% [11/25]
How many of these victim advocates receive the 40 hour training?					
<i>All</i>	48.6% [17/35]	72.7% [8/11]**	37.5% [9/24]	50% [5/10]	48% [12/25]
<i>Most</i>	8.6% [3/35]	18.2% [2/11]	4.1% [1/24]	20% [2/10]	4% [1/25]
<i>Some</i>	8.6% [3/35]	—	12.5% [3/24]	—	12% [3/25]
<i>None</i>	17.1% [6/35]	9.1% [1/11]	20.8% [5/24]	20% [2/10]	16% [4/25]
<i>I don't know</i>	17.1% [6/35]	—	25% [6/24]	10% [1/10]	20% [5/25]
On call schedule for victim advocates?	80% [28/35]	90.9% [10/11]	75% [18/24]	90% [9/10]	76% [19/25]
Back-up on-call schedule for victim advocates?					
<i>Yes</i>	62.9% [22/35]	90% [9/10]	72.2% [13/18]	88.8% [8/9]**	73.6% [14/19]
<i>I don't know</i>	8.6% [3/35]	10% [1/10]	11.1% [2/18]	—	15.7% [3/19]
How often exam begins before advocate is present?					
<i>Always</i>	15.4% [6/39]	—	21.4% [6/28]	—	21.4% [6/28]
<i>Most of the Time</i>	12.8% [5/39]	—	17.8% [5/28]	—	17.9% [5/28]
<i>Sometimes</i>	28.2% [11/39]	18.2% [2/11]*	32.1% [9/28]	40% [4/10]*	25.0% [7/28]
<i>Rarely</i>	28.2% [11/39]	54.5% [6/11]	17.8% [5/28]	30% [3/10]	28.6% [8/28]
<i>Never</i>	12.8% [5/39]	27.3% [3/11]	7.1% [2/28]	30% [3/10]	7.1% [2/28]
<i>I don't know</i>	2.6% [1/39]	—	3.5% [1/28]	—	—

* p<.05, ** p<.01, t-test run between SAFE and non-SAFE and between private and public EDs

Many EDs (48.6%) use a combination of hospital social workers, staff and volunteer advocates. Nearly half (45.5%) of the SAFE Centers of Excellence report utilizing a combination of volunteer advocates and hospital social workers, 36% use only volunteer advocates, and 18.1% use only hospital staff. A similar pattern emerges among non-SAFE EDs with half (50%) reporting that their advocates comprise both hospital staff and volunteer advocates. Timing appears to ultimately determine which type of advocate a victim receives: hospital social workers are usually assigned in the day; rape crisis programs provide volunteer advocates on nights and weekends.

Many public (60%) and private (44%) EDs use a combination of volunteer advocates and hospital staff, as well as EDs in Brooklyn (40%) and Manhattan (64.3%). However, significantly more Queens EDs (57.1%) use hospital social workers than those in the other boroughs ($p < .01$).

Less than half (48.6%) of the EDs surveyed reported that 'all' of the victim advocates who work with sexual assault survivors in their ED have received the 40-hour training offered through rape crisis programs throughout the City. Seventeen percent of the respondents reported that none of the victim advocates had received the training, and another seventeen percent did not know if the advocates they work with had received the training.

The majority of EDs (56.4%) reported that the exam began 'sometimes,' 'most of the time,' or 'always' before the victim advocate was present.

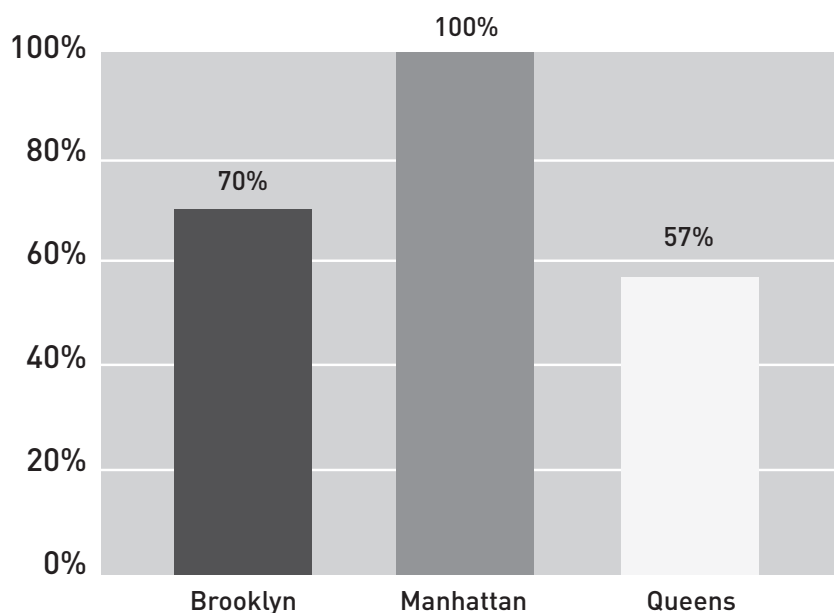
Availability of Victim Advocates

When a patient seeks acute care services for a sexual assault, the triage nurse should alert the on-call SAFE or attending doctor and a victim advocate. Advocates accompany the patient and act as a liaison with doctors and police.

Having an on-call schedule is important to provide 24-hour advocate coverage for sexual assault patients. Eighty percent of EDs surveyed reported having an on-call schedule for their victim advocates. More SAFE Centers of Excellence reported having on-call schedules for advocates than non-SAFE EDs (90.9% vs. 75%). Likewise, more public EDs reported having on-call schedules for their advocates than private EDs (90% vs. 76%).

Figure 2 shows the percentage of EDs with an on-call schedule for victim advocates by borough. All of the Manhattan EDs surveyed have an on-call schedule for victim advocates, compared to 57% of Queens EDs and 70% in Brooklyn.

Figure 2: Percentage of EDs with On-call Schedule for Victim Advocates by Borough



Rape Crisis Advocates: Evidence-Based Best Practice

“Hospitals need to acknowledge that people who were raped before rape advocates evolved, were considered the instigators and this is something we will always live with...”
—50-year-old female (New York City Alliance Against Sexual Assault, 2007)

Rape crisis advocates provide emotional support to a victim of sexual assault in the hospital setting and may accompany victims from the initial contact and the actual exam to discharge and follow-up. Since they are not affiliated with law enforcement or criminal justice agencies, advocates can provide emotional support to the victim while remaining separate from the criminal investigation (Carmody, 2006). At the same time advocates also work to prevent what is called “secondary victimization,” or the insensitive, victim-blaming behaviors of service providers and responders that increase the trauma of the rape (Campbell, 2006).

Recent research has focused on the effectiveness of rape crisis advocates to both improve service delivery to survivors and to prevent secondary victimizations in the law enforcement and acute care settings. A study conducted by Rebecca Campbell (2006) interviewed eighty-one survivors in hospitals after an assault about the services received from legal and medical system personnel and how they were treated during these interactions. Findings showed that survivors who had the assistance of a rape crisis advocate were more likely to have police reports taken and less likely to be treated negatively by the police (Campbell, 2006).

Likewise, survivors who were accompanied by an advocate in the emergency department were significantly more likely to receive information on STDs and the risk of HIV, and were more likely to receive STD prophylaxis and emergency contraception than women from the hospital who did not have a rape crisis advocate present (Campbell, 2006). Also, victims who worked with advocates were less likely to report being treated impersonally or coldly by hospital staff, being asked how they were dressed at the time of the assault, or asked about prior sexual

histories than survivors who did not work with a victim advocate (Campbell, 2006). In the hospital that did not utilize victim advocates, survivors were significantly more likely to be asked by medical staff if they had responded sexually to the assault than survivors who worked with victim advocates (Campbell, 2006). Lastly, survivors who did not have a rape crisis advocate were more likely to report blaming themselves for the assault and were significantly more likely to state that they were reluctant to seek further help (Campbell, 2006).

In our companion study, *A Room of Our Own: Survivors Evaluate Services*, sexual assault survivors in NYC were significantly more satisfied with the care they received at the hospital if a rape crisis advocate was present (New York City Alliance Against Sexual Assault, 2007). When survivors were asked what recommendations they had for improving care at the hospital level in NYC, the most frequent recommendation was to have rape crisis advocates available for survivors (New York City Alliance Against Sexual Assault, 2007).

Rape crisis advocates also positively impact chart documentation in the acute care setting. In a study conducted at the Sexual Assault Violence Intervention (SAVI) program at Mt. Sinai Hospital, 153 sexual assault patient charts were reviewed from 1998 to 2002. The study examined inappropriate documentation, which was defined as either 1) inclusion of a medical and forensic history that contained an interview/investigation outside the purview of patient diagnosis and care, or 2) the use of judgmental terminology such as the word “alleged” or the use of evaluative and/or interpretive words in the patient’s story was undermined or minimized by the clinician (Kahn & Frounfelker, 2005). The study found that the presence of a volunteer rape crisis advocate was a statistically significant protective factor leading to a decreased likelihood of the use of the word “alleged” in the chart documentation of sexual assault patients (Kahn & Frounfelker, 2005).

Chapter 5: Quality Assurance

Quality Assurance (QA), also known as Quality Improvement, is the systematic process of measuring quality in services with the desire to improve those services. Quality Assurance in the treatment of sexual assault patients in the acute care setting is an important but often overlooked process.

For QA, we measured: 1) whether the ED participated in an interdisciplinary taskforce focused on sexual violence; 2) whether the ED had done any community outreach about their services in the last six months; 3) among SAFE EDs, whether all staff received an orientation to the program; 4) whether the hospital ED ran into problems releasing information or evidence to detectives or Assistant District Attorney's (ADAs); 5) whether there was an established system of QA in place for patients reporting a sexual assault; 6) whether chart audits were routinely conducted on sexual assault patients; 7) whether they have conducted a patient satisfaction survey in the last two years; and 8) whether there was collection of any additional data beyond diagnostic codes.

DOH-certified SAFE Centers of Excellence are required to participate in an interdisciplinary taskforce that includes local rape crisis programs, law enforcement representatives and local prosecutors to develop services that meet community needs and to ensure that quality victim services are available. These taskforce meetings can also serve as a forum for issues that arise in clinical practice or with law enforcement or criminal justice.

Many EDs surveyed (64.5%) reported participating on an interdisciplinary taskforce. Of these, 35% participate monthly; 60% participate every two to six months, on average; and 5% participate every six to twelve months. Nearly all the SAFE Centers of Excellence (81.8%) participate in one of these taskforces, compared to 57.8% of non-SAFE EDs.

Outreach to the community about the services offered to sexual assault patients can help ensure quality by engaging the community in discussions

about ED services. All of the SAFE Centers of Excellence had conducted outreach in the community in the six months preceding the survey, compared to only 35% of non-SAFE EDs. Most, or 70%, of the public hospital EDs and half (50%) of the private EDs reported conducting outreach.

It is crucial that the entire ED staff knows if there is a specialized SAFE Center in a hospital ED or a trained SAFE clinician working there. When patients walk into the emergency department or come from another department, they need these specialized services. It is also important that all members of the ED are trained on the protocols so they can provide care for sexual assault patients consistent with established standards. We asked whether an orientation had been given to the entire ED on their services. Nearly all (90.9%) of the SAFE Centers of Excellence had given all ED staff an orientation to the SAFE services, and all of the non-SAFE EDs with several trained examiners gave an orientation to other ED staff on the SAFE services they offered in their hospital.

Only a small percentage of EDs (20.5%) reported problems releasing information to detectives or ADAs. When asked what these problems entailed, half reported that police officers demand evidence without the patient's consent or the provider's opinion on the case. Another 25% mentioned that the risk management and hospital records departments sometimes pose barriers to detectives and ADAs. One respondent also reported that the Department of Corrections requested information on prisoners who were patients.

Nearly three-quarters (71.8%) of EDs sampled have an established system of quality assurance specific to patients reporting sexual assault. Most SAFE Centers of Excellence (90.9%) have established QA systems, compared to 64.2% of non-SAFE EDs (Table 11). All public hospital EDs have established QA systems, compared to 62.1% of private hospital EDs.

Table 11: Quality Assurance Variables by Hospital Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Established system of QA for patients reporting sexual assault? <i>Yes</i>	71.8% (28/39)	90.9% (10/11)	64.2% (18/28)	100%(10/10)***	62.1% (18/29)
Chart audits routinely conducted on patients reporting sexual as- sault? <i>Yes</i> <i>I don't know</i>	71.8% (28/39) 2.6% (1/39)	90.9% (10/11) —	64.2% (18/28) 3.5% (1/28)	100% (10/10)** —	62.1% (18/29) 3.4% (1/29)
Collection of any ad- ditional data beyond diagnostic codes? <i>Yes</i> <i>I don't know</i>	28.2% (11/39) 7.7% (3/39)	54.5% (6/11) —	17.8% (5/28) 10.7% (3/28)	30% (3/10) —	27.6% (8/29) —

** p<.01, *** p<.001 t-test between private and public EDs

A chart audit is an examination of medical records (electronic and/or hard copy), to determine what has been done and to see if it can be done better (Duke University Medical Center, 2005). EDs that have protocols for the care of sexual assault patients can use audits to assess how well they are following these protocols. Many of the EDs surveyed (71.8%) routinely conduct audits on sexual assault

patient charts. SAFE Centers of Excellence are more likely to conduct audits than non-SAFE EDs (90.9% vs. 64.2%). Similarly, all public EDs reported that they conduct sexual assault-specific chart audits, compared to 62.1% of private EDs. Only one ED has conducted a patient satisfaction survey in the last two years.

Quality Assurance Frameworks

Quality in healthcare is often defined as providing client-centered services and meeting clients' needs (Berwick et al., 1990 as cited in Engenderhealth, 2003). There are many reasons to work toward improving quality in the acute care setting: improved quality safeguards the health of both clients and staff, attracts clients, maintains the organization's strengths and leads to savings (less repeat work and waste) and in the field of acute care response to sexual violence may decrease the secondary victimization experienced by survivors by reducing victim-blaming and insensitive behaviors on the part of health care staff. Quality assurance is an effort that seeks to continuously do things better until they are done right the first time, every time (Engenderhealth, 2003).

There are three major frameworks of quality assurance that will be described here: 1) COPE: Client-Oriented, Provider-Efficient Services, 2) PI: Performance Improvement, and 3) AI: Appreciative Inquiry.

COPE, which stands for Client-Oriented and Provider-Efficient Services, is a trademark of Engenderhealth and has been used to improve health care services in many developing countries. COPE is a participatory quality assurance framework embodied by the idea that changes in quality will be most successful and lasting when they are initiated by staff working together within the facility, using their expertise to identify problems and develop recommendations for solving these problems (Engenderhealth, 2003). The definition of quality in COPE incorporates clients' rights to quality care and staff needs for the support (supervision, training, supplies and equipment) that will ensure their clients receive that level of care (Engenderhealth, 2003).

COPE is a quality improvement (QI) framework in that it defines quality services using clients' rights as the overarching standard and assessing them through client interviews, staff self-assessments, and community activities (Engenderhealth, 2003). The main question in QI is what steps can we take to make sure we do the right thing in the right way (Engenderhealth, 2003)? The COPE handbook includes sample tools and exercises to facilitate the COPE process at any health facility.

Performance Improvement, or PI, is a performance-driven measure that defines desired performance through the standards set by stakeholders and asks the question: what is needed to improve performance? Results are achieved through a systematic process that: 1) considers the institutional context; 2) describes desired performance; 3) identifies gaps between desired and actual performance; 4) identifies root causes; 5) selects, designs, and implements interventions to fix the root causes; and 6) measures changes in performance (Engenderhealth, 2003).

Appreciative Inquiry, or AI, is a capacity-building process that focuses on an organization's strengths developed by David Cooperrider of Case Western Reserve University. In AI, this process has four stages known as the discovery, dream, design and destiny phases (the 4-D cycle). **Discover:** The identification of organizational processes that work well. **Dream:** The envisioning of processes that would work well in the future. **Design:** Planning and prioritizing processes that would work well. **Destiny:** The implementation (execution) of the proposed design (AI Commons, 2007). The basic idea is to create organizations around what works, rather than trying to fix existing problems.

More than one quarter (28.2%) of the EDs collect additional data beyond diagnostic codes on patients reporting sexual assaults. More than half (54.5%) of the SAFE Centers of Excellence collect additional data on their patients, compared to 17.8% of non-SAFE EDs. Among those collecting additional data, they reported the following types of information:

- If HIV PEP was offered,
- If EC was offered,
- Time of arrival of patient being seen,
- If a victim advocate was present,
- If there were any weapons involved in the assault,
- If STI prophylaxis was refused,
- If STI prophylaxis was administered,
- Social work referrals made,
- Demographics and variables around the assault (stranger or acquaintance),
- If the colposcope was used, and
- If photos were taken.

Chapter 6: Implications

This study provides a snapshot of services available to sexual assault victims in New York City's emergency departments, including the strengths and weaknesses of current resources in the acute care setting. The implications of these findings in each of the five areas researched will be discussed: 1) availability of Sexual Assault Forensic Examiner Programs in NYC; 2) medical care for sexual assault patients; 3) forensic evidence collection; 4) information, advocacy and follow-up services; and 5) quality assurance.

Availability of Sexual Assault Forensic Examiner Programs in NYC

A survivor of sexual assault in New York City could receive very different health care depending on which hospital they visit. The results of this study demonstrate that SAFE Centers of Excellence provide the most comprehensive care for sexual assault patients; such programs should be available and accessible to *all* New Yorkers.

Currently, these programs are distributed in a non-systematic fashion throughout the city. There are two important areas to be addressed:

1. What is the number of SAFE programs that are still needed in NYC, and where should they be located?
2. How can New Yorkers know about and access these programs when they are needed?

Access to SAFE Programs

While it is important to have SAFE programs in place, it is equally important that sexual assault patients be seen at these programs instead of at emergency departments without specialized services. There are three main issues related to the accessibility of SAFE programs: 1) ambulance destination designation for SAFE Centers, 2) hospital-

to-hospital transfer agreements, and 3) increased public knowledge about SAFE programs and where they are located.

Unless a patient requests transport to a specific facility, FDNY EMS must transport sexual assault patients to the nearest 911-receiving ED, regardless of whether or not other local facilities provide more specialized care for sexual assault. According to hospitals and, ultimately, the state, all emergency department facilities must be able to medically manage sexual assault patients. Granting SAFE Centers of Excellence status as EMS destinations will facilitate transport of medically stable sexual assault patients to the nearest SAFE center. Moving such a designation forward will involve collaboration between FDNY EMS, the Regional Emergency Medical Services Council of New York City (REMSCO), the Regional Medical Advisory Committee (REMAC), and the State DOH Bureau of EMS (New York City Alliance Against Sexual Assault, 2005a).

Issues affecting sexual assault patients who “walk in” to emergency rooms

Some sexual assault patients are not brought to the hospital by an ambulance but instead walk into the ED. In order for sexual assault patients to have access to the best care available at SAFE Centers, transfer agreements need to be put in place to transport a stable patient from a non-SAFE to a SAFE Center. The logistics of transferring patients from hospitals without SAFE programs to designated SAFE Centers involves careful consideration of the Emergency Medical Treatment and Active Labor Act (EMTALA) and medical transfer rules.

EMTALA, which applies to all hospitals that participate in the federal Medicare program, imposes two primary obligations on those hospitals. First, when an individual presents for treatment at a hospital's emergency room, “the hospital must provide for an appropriate medical screening examination...to determine whether or not an emergency medical

condition” exists [42 U.S.C. § 1395dd(a)]. Second, if the screening examination indicates that an emergency medical condition does exist, the hospital ordinarily must “stabilize the medical condition” before transferring or discharging the patient (Id. § 1395dd(b)(1)(A)). With respect to facilitating a SAFE Center model, EMTALA would require a “fast-track” screening examination by non-SAFE facilities for those patients who agree to be transferred to SAFE Centers for their care.

Public Knowledge of SAFE Programs

Although transfer protocols are critical, they should exist only as a back-up plan. The SAFE Center model should depend more strongly on the public *knowing* where specialized care exists, so that sexual assault patients pursue care at SAFE centers first, not requiring a transfer. As such, facilitating the SAFE Center model will also require the development of a communication campaign that informs the public about what SAFE Centers are and where they exist.

City Commitment to SAFE Programs

The New York City Health and Hospital Corporation’s (HHC) commitment to developing SAFE programs in all public hospitals appears to be unique nationally. Leadership from the Mayor’s office has jump-started efforts in every HHC hospital to improve services to rape victims. The value of one-time federal or city discretionary funding spearheaded by the Mayor’s office for these initiatives cannot be overstated, as funding of SAFE programs continues to be an ongoing struggle.

Leadership and political will go a long way toward large-scale changes, such as developing SAFE programs in multiple emergency departments. The findings of this study underscore how public hospitals have made tremendous strides in providing care for survivors of sexual violence. This is due, in part, to the dedication of key policymakers and government officials.

The next step toward ensuring universal access to the best standard of care for all sexual assault victims in New York City will involve detailed conversation and brainstorming among many key stakeholders. The SAFE Center model, as described above, will require tremendous cooperation between hospital systems and the nurturing of new partnerships. It also must allow for the development of new SAFE programs in underserved areas. This means building in a mechanism for new examiners to train and new programs to develop, while still ensuring best care for all. This may require collaborative agreements, and allowing new SAFE examiners to complete preceptorships at established SAFE programs in order to staff newly forming programs.

Only the sustained political will and social commitment can ensure that *all* sexual assault patients in New York City receive the same standard of care, no matter where they are treated. The city should continue to support these programs.

Medical Care for Sexual Assault Patients

We found that SAFE Centers of Excellence reported providing medical care that closely mirrors the NYS DOH’s *Protocol for the Acute Care of the Adult Patient Reporting a Sexual Assault*—the best practice standard of care in NYS (2004). A few issues raised in the data that should be further examined include: 1) preceptorship of SAFE clinicians, 2) ongoing training of SAFE clinicians, 3) testing versus providing prophylaxis for STIs, and 4) guiding principles for either the referral of child/adolescent cases to Child Advocacy Centers or their treatment at SAFE Centers.

More providers than ever are taking the five-day SAFE training course, but the number of NYS DOH-certified SAFE providers is still low. Upon completion of the SAFE course, all providers must be precepted (i.e. supervised doing a certain number of exams and passing all the proficiencies required to become a certified SAFE clinician). For hospitals with a small number of experienced SAFE clinicians or those just beginning a SAFE program, it may be impossible to find someone within their own hospital who can act as a preceptor. Due to the complica

tions of credentialing, it is hard for outside doctors to come into a new hospital in order to act as a preceptor. Further research should be conducted on how to ensure acumen of SAFE clinicians.

The NYS DOH Protocol states that SAFE clinicians must engage in ongoing learning around sexual assault. However, we found that many EDs are not able to offer these opportunities to their examiners in a systematic fashion. Sustained training needs to be provided to SAFE clinicians, such as continuing education credentialing like Continuing Medical Education (CME) credits for local sexual assault-focused forums, conferences and workshops.

Many hospital EDs report following varied protocols around the acute care response for STIs for sexual assault patients. This is congruent with the current national debate around STI testing. While the NYS DOH protocol is very clear on what should be done, it is important to conduct research-to-practice forums around what is prosecutorially evidence-based.

ED administrators and examiners did not provide consistent answers when asked about adult versus child protocols usage in the management of sexual assault cases. Furthermore, there are not any written guidelines on how to determine when a patient should be treated using the adult protocol. A workgroup with clinicians should be held to establish guidelines on when to refer child/teen cases to Child Advocacy Centers (CACs) and when to treat at SAFE Centers.

Forensic Evidence Collection

SAFE Centers of Excellence reported in this study that they collect forensic evidence within the guidelines as set for by the NYS DOH's Protocol (2004). A few areas for further clarification include: 1) whether kits are stored or turned directly over to the police, 2) using standardized evidence collection kits, 3) length of kit storage time, and 4) contacting victims prior to throwing away kits.

New York State is a non-mandatory reporting state, meaning that sexual assault patients decide if they want to report assaults to law enforcement. When ED directors and practitioners were asked if they stored kits, many replied that they turn all the kits

over to the police. More research needs to be conducted to determine whether they do this with the patient's consent. Also, these kits are free through the New York State Division of Criminal Justice Services (DCJS) and help ensure that all evidence collection occurs in a systematic and controlled fashion. Unlike our results, no hospitals should be reporting that they do not use these kits, including the Drug Facilitated Sexual Assault Kit.

Several hospital EDs reported storing kits for less than 30 days, the current mandatory time required. More research should be done to find out barriers to storing kits. If it is a logistical issue, then these issues should be addressed.

Very few EDs, including SAFE Centers of Excellence, reported contacting a victim prior to throwing away their evidence collection kit. More discussion should determine if there are ways to follow-up with these patients about the disposal of their kits. Specifically, qualitative research with survivors would be helpful to determine best practice for contacting patients who choose to store evidence collection kits at the hospital.

Information, Advocacy and Follow-Up

Consistently, SAFE Centers of Excellence reported providing information, advocacy and follow-up services more often than non-SAFE EDs. Related implications include: 1) 24-hour coverage by advocates, 2) volunteer versus hospital social workers or hospital staff as victim advocates, 3) the provision of standardized low-literacy literature for sexual assault patients, 4) the provision of these materials in languages other than English, and 5) the difficulties of follow-up.

The crucial role of advocates in terms of providing quality treatment and eventual recovery from trauma cannot be overstated. Based on the research showing the importance of rape crisis advocates, all EDs in NYC should use victim advocates. In order for this to occur, more rape crisis programs need to be established outside of Manhattan, and more funding needs to be given to existing rape crisis programs so that they can expand their advocate services to more emergency departments.

Many hospitals use a mixture of volunteer community members, hospital social workers and other hospital staff to provide advocacy for sexual assault patients in the emergency department. More research is needed to elicit what difference on the quality of care, if any, results from using hospital staff as advocates versus volunteer rape crisis advocates.

There is a great need for victims of sexual assault to receive adequate information both verbally and in the form of pamphlets regarding follow-up care for sexual assault, HIV testing, and STIs. While many EDs report providing literature in different languages, this varied across hospitals. Aside from the NYS DOH-produced literature on emergency contraception, there seems to be no standardized literature available to patients reporting a sexual assault. Furthermore, it is unclear whether the brochures used for all topics have been developed with low-literacy populations in mind. More standardized literature should be developed, using a health communication framework that includes gathering input from SAFE programs, rape crisis programs, survivors and other key stakeholders on language. Brochures are especially needed on HIV PEP and STIs.

It is also crucial that resources be available in a multitude of languages. The population of New York City is very diverse and inhabitants include individuals from 180 countries worldwide. Additionally, according to the U.S. Census 2000, 48% of individuals living in New York City spoke a language other than English in their homes. The diverse NYC population should have full access to all services and assistance possible following a sexual assault. Hospitals must increase the amount of literature

they provide to non-English speaking individuals regarding follow-up care, HIV medication, and STIs. This means that all of the patient literature should be translated into several key languages, such as Spanish and Chinese, among others.

Follow-up with sexual assault patients is very low for both specialized SAFE programs and for non-SAFE EDs. The reasons are well-understood, as patients often do not want to be contacted after they are seen in the ED. Further research needs to be conducted to analyze if there are methods of follow-up that would be acceptable to sexual assault patients.

Quality Assurance

Quality assurance is an area where much more work can be done on the part of SAFE Centers to measure the quality of care provided to patients and to work towards improvement. One recommendation would be to adapt a quality improvement manual, such as the Client-Oriented and Provider-Efficient Services (COPE) framework described in chapter 5, to the specific needs of Sexual Assault Forensic Examiner Programs. This would allow more quality assurance exercises to take place within EDs for the treatment of patients reporting sexual assaults and the crucial inclusion of survivor input into these services.

Table 12: Summary of Recommendation Based on Study Findings

Availability of SAFE Programs	Medical Treatment	Forensic Evidence Collection	Information, Advocacy and Follow-Up	Quality Assurance
Establish critical number of SAFE Centers in NYC.	Research on how to ensure acumen of SAFE clinicians.	Follow-up research on hospitals' protocols and procedures on releasing evidence collection kits to the police.	Work towards ensuring all EDs in NYC utilize victim advocates for sexual assault patients by creating more RCPs and providing more funding to current RCPs to expand their coverage.	Develop QI manual, such as COPE, that is specific to SAFE Centers.
Develop ambulance destination designation for SAFE Centers.	The Alliance and other organizations provide continuing education credentialing for sexual assault forums, conferences and workshops.	Outreach to all EDs on the availability of the free standardized NYS Sexual Offense Evidence Collection Kit and the DFSA Kit.	Research to determine if sexual assault patients are differently impacted by staff social workers versus volunteer victim advocates.	Include survivors in quality improvement exercises.
Develop transfer protocols for patients from non-SAFE to SAFE Centers.	Conduct research to practice forum for providers about the current prosecutorial evidence-base for testing vs. not testing for STIs.	More research on hospital barriers to storing kits.	Use a health communication framework to develop standardized low-literacy brochures for sexual assault patients on HIV PEP and STIs as well as other relevant issues.	
Develop communications campaign to let New Yorkers know what SAFE Programs are and where they exist.	Develop workgroup to establish guidelines on when to refer child/teen cases to CACs and when to treat at SAFE Centers.	Qualitative research with survivors to determine best practice with regard to contacting patients before discarding evidence collection kits.	Use a health communication framework to develop standardized low-literacy brochures for sexual assault patients in languages other than English.	
			Conduct research on the barriers to follow-up and methods that would be acceptable to sexual assault patients.	

We have made great strides in establishing best care guidelines for sexual assault patients in NYC's emergency departments. Since the first mapping of services conducted by the Rape Treatment Consortium in 1996, we have established more

comprehensive SAFE programs to care for sexual assault patients. As advocates, policymakers, city officials and community members, we now must work to ensure that all New Yorkers have access to these services.

References

- Anderson, S., McClain, N., & Riviello, R.J. (2006). Genital findings of women after consensual and non-consensual intercourse. *Journal of Forensic Nursing*, 2(2), 59-59-65.
- AP Wire. (2007, March 13). *Bill requiring morning after pill in all hospitals under heavy debate*. Retrieved March 29, 2007 from <http://wcbs880.com/pages/300489.php?contentType=4&contentId=372026>.
- Appreciative Inquiry Commons. *What is Appreciative Inquiry?* Retrieved March 22, 2007 from <http://appreciativeinquiry.case.edu/intro/whatisai.cfm>.
- Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women*, 12(1), 30-44.
- Campbell, R., Patterson D., & Lichty, L. F. (2005). Effectiveness of Sexual Assault Nurse Examiner (SANE) programs: A review of psychological, medical, legal and community outcomes. *Trauma, Violence and Abuse*, 6(4), 313-329.
- Carmody, D.C. (2006). Sexual assault victim advocates in Virginia: Challenges faced in the field. *Journal of Health and Human Services Administration* 29(1), 191-208.
- Centers for Disease Control (2005). Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services. *Morbidity and Mortality Weekly Report*, 54(RR-2), 2-16.
- Ciancone, A. C., Wilson, C., Collette, R., & Gerson, L. W. (2000). Sexual Assault Nurse Examiner programs in the United States. *Annals of Emergency Medicine*, 35(4), 353-357.
- DNA Sexual Assault Justice Act of 2002, US 107th Congress S. 2513[107]. Retrieved from <http://www.govtrack.us/congress/bill.xpd?bill=s107-2513>.
- Duke University Medical Center. *What is a Chart Audit?* Retrieved March 2, 2007 from http://patientsafetyed.duhs.duke.edu/module_b/chart_audit.html
- Engenderhealth. (2003). *COPE® handbook: A process for improving quality in health services*, revised edition. New York.
- Food and Drug Administration. (1998). *FDA approves application for PREVEN emergency contraception kit*. Retrieved on March 30, 2007 from <http://www.fda.gov/bbs/topics/ANSWERS/ANS00892.html>.
- GovTrack. (2006). Retrieved October 12, 2006 from <http://www.govtrack.us/congress/bill.xpd?bill=h109-3402>.
- International Association of Forensic Nurses (IAFN). (2006). *SANE/SAFE/SART Registry*. Retrieved December 15, 2006 from: <http://www.forensicnurse.org/resources/default.html>.
- Kaiser Family Foundation. (1997). *Emergency contraception: Is the secret getting out? National survey of Americans and health care providers on emergency contraception*. Retrieved on March 17, 2007 from <http://www.kff.org/content/archive/1352/>
- Kahn, A. R., Frounfelker, R. L. (2005). *Evaluating medical staff responses to sexual assault survivors in the ED*. Unpublished abstract.
- Ledray, L. (2005). Data on SANE programs crucial to refining the specialty, improving care. *Journal of Forensic Nursing*. 1(4): 187-188.
- Lenahan, L. C., Ernst, A., & Johnson, B. (1998). Colposcopy in evaluation of the adult sexual assault victim. *American Journal of Emergency Medicine*, 16(2), 183-184.
- Library of Congress. (2002). *Rape kit DNA analysis backlog elimination act of 2002 (Introduced in Senate)*. Retrieved March 30, 2007 from <http://thomas.loc.gov/cgi-bin/query/z?c107:S.2318.IS>.
- Little, K. (2001). *Sexual Assault Nurse Examiner (SANE) programs: Improving the community response to Sexual Assault Victims' Office for Victims of Crime Bulletin*. Washington, DC: US Department of Justice.

Mears, C.J., Heflin, A.H., Finkel, M.A., Deblinger, E. & Steer, R.A. (2003). Adolescents' responses to sexual abuse evaluation including the use of video colposcopy. *Journal of Adolescent Health*, 33(1), 18-24.

The National Center on Domestic and Sexual Violence (NCDSV). (2006). *For immediate release*. Retrieved on September 20, 2006 from <http://www.ncdsv.org/images/MayorBloombergAnnouncesExpansionSART.pdf>.

New York City (March 30, 2005.) *Mayor Michael R. Bloomberg announces expansion of sexual assault response team program to public hospitals citywide*. Press Release.

The New York City Alliance Against Sexual Assault. (2005a). *SAFE in the city: Executive summary of initial interviews with key stakeholders*. New York.

The New York City Alliance Against Sexual Assault. (2005b). *New York State laws*. Retrieved October 5, 2006 from http://www.nycagainstrape.org/survivors_legal.html.

The New York City Alliance Against Sexual Assault. (2007, April). *A room of our own: survivors evaluate services* (Research Report). New York: Deborah Fry.

New York City Council. (2006a). *Current local laws*. Retrieved September 29, 2006 from http://www.nyc-council.info/pdf_files/bills/law03026.pdf.

New York City Council. (2006b). *Current local laws*. Retrieved September 29, 2006 from http://www.nyc-council.info/pdf_files/bills/law03025.pdf.

New York City Council. (2006c). *Current local laws*. Retrieved September 29, 2006 from http://www.nyc-council.info/pdf_files/bills/law03075.pdf.

New York City Council. (2007). *Current local laws*. Retrieved February 22, 2007 from http://www.nyccouncil.info/pdf_files/bills/law03019.pdf.

New York State Assembly. (2006a). *New York State bill search*. Retrieved on October 5, 2006 from <http://assembly.state.ny.us/leg/?bn=A12012>.

New York State Assembly. (June 23, 2006b). *Assembly overwhelmingly gives final legislative approval to DNA databank expansion legislation*. Press Release.

New York State Crime Victims Board. (2006a). *Victim support services*. Retrieved on October 12, 2006 from <http://www.cvb.state.ny.us/services.htm>.

New York State Crime Victims Board (CVB). (2006b) *Direct reimbursement of forensic RAPE/Sexual assault examinations (FRE)*. Retrieved December 15, 2006 from [http://www.cvb.state.ny.us/FRE.htm#What%20is%20the%20Forensic%20Rape%20Examination%20\(FRE\)%20Direct%20Payment%20Program?](http://www.cvb.state.ny.us/FRE.htm#What%20is%20the%20Forensic%20Rape%20Examination%20(FRE)%20Direct%20Payment%20Program?).

New York State Crime Victims Board. (2006c). *Sexual assault advocate guide*. Retrieved October 12, 2006 from http://www.cvb.state.ny.us/forms/CVB_Adv-Guide_SexAssault_revEAM.pdf.

New York State Department of Health. (1991). *Sexual offense evidence collection protocol*. Retrieved on March 24, 2007 from <http://www.ahrq.gov/research/victsexual/victappb3.htm>.

New York State Department of Health. (2002). *The New York State Sexual Assault Reform Act (SARA) Sexual Assault Forensic Examiner (SAFE)*. Retrieved on November 24, 2005 from <http://w2.health.state.ny.us/query.html?col=nysdoh&qt=SAFE&search.x=0&search.y=0&search=Search>.

New York State Department of Health. (2004). *Protocol for the acute care of the adult patient reporting sexual assault*. Retrieved May 2006 from http://www.health.state.ny.us/professionals/protocols_and_guidelines/sexual_assault/index.htm

New York State Department of Health. (2006a). *SAFE centers*. Retrieved February 15, 2007 from http://hospitals.nyhealth.gov/browse_search.php?form=CENTER&rt=6

New York State Department of Health. (2006b). *Laws and regulations*. Retrieved on October 12, 2006 from <http://w3.health.state.ny.us/dbspace/NYCRR10.nsf>

New York State Department of Health AIDS Institute. (2006). *HIV clinical guidelines*. Retrieved on October 12, 2006 from <http://www.hivguidelines.org/GuideLine.aspx?pageID=78&guideLineID=2>.

New York State Division of Criminal Justice Services. (2005). *Sexual assault*. Retrieved on October 12, 2006 from <http://criminaljustice.state.ny.us/ofpa/evidencekit.htm>.

- New York State Division of State Police. (2006). *Forensic science*. Retrieved October 5, 2006 from http://www.troopers.state.ny.us/Forensic_Science/DNA/.
- New York State Governor's Office (February 23, 2000). *End statute of limitations on rape, expand DNA data-bank*. Press release. http://www.state.ny.us/governor/press/00/feb23_00.htm.
- New York State Public Health Law. (2002). Treatment of Sexual Offense Victims and Maintenance of Evidence in a Sexual Offense, §2805-I.
- NYC.gov. (2004). *News from the blue room*. Retrieved September 20, 2006 from http://www.nyc.gov/portal/site/nycgov/menuitem.c0935b9a57bb4ef3daf2f1c701c789a0/index.jsp?pagelD=mayor_press_release&catID=1194&doc_name=http%3A%2F%2Fwww.nyc.gov%2Fhtml%2Fom%2Fhtml%2F2004a%2Fpr039-04.html&cc=unused1978&rc=1194&ndi=1.
- Office of New York State Attorney General Eliot Spitzer. (2006). *OAG reference guides*. Retrieved November 6, 2006 from <http://www.oag.state.ny.us/crime/CrimeVictimsLegislationTL.html>.
- Office of the New York State Comptroller. (November 6, 2003). *Improved access to emergency contraception could prevent unwanted pregnancies and abortions and save New York \$450 million annually*. Press Release.
- Office of Temporary and Disability Assistance of New York State. (1996). Local Commissioners Memorandum. *Subject: child and adolescent sexual offense medical protocol*. Retrieved March 30, 2007 from www.otda.state.ny.us/directives/1996/LCM/96_LCM-104.pdf.
- Patel, A., Simons, R., Piotrowski, Z.H., Shulman, L., Petraitis, C. (2004). Under-use of emergency contraception for victims of sexual assault. *International Journal of Fertility Women's Medicine*, 49(6), 269-273.
- Pharmacy Access Partnership. (February 1, 2007). *New York steps ahead of curve with Medicaid coverage of Plan B OTC*. Press Release.
- Planned Parenthood Federation of America. (2003). *A brief history of emergency hormonal contraception*. Retrieved March 30, 2007 from www.ppinc.org/upoad/ECHistory.pdf.
- Quindlen, A. (1994, October 19). After the rape. *The New York Times*, Op-Ed.
- Rape Crisis Network Europe. (2003, July). *Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations* (Briefing Paper for the Daphne Strengthening the Linkages Project). London: Liz Kelly and Linda Regan.
- Santucci, K.A., Nelson, D.G., McQuillen, K.K., Duffy, S.J. & Linakis, J.G. (1999). Wood's lamp utility in the identification of semen. *Pediatrics* 104(6): 1342-1344.
- Sklar, K.K., & Lustig, S. (2001). *How have recent social movements shaped civil rights legislation for women? The 1994 violence against women act*. State University of New York at Binghamton. Retrieved on November 6, 2006 from <http://www.binghamton.edu/womhist/vawa/intro.htm>.
- Slaughter, L., & Brown, C. R. (1992). Colposcopy to establish physical findings in rape victims. *American Journal of Obstetrics and Gynecology*, 166(1), 83-6.
- Taskforce on Postovulatory Methods of Fertility Regulation. (1998). Randomised controlled trial of Levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *The Lancet*, 352(9126), 428-433.
- Templeton, D.J. & Williams, A. (2006). Current issues in the use of colposcopy for examination of sexual assault victims. *Sexual Health*, 3(1), 5-10.
- U.S. Department of Justice Office of Justice Programs. (2006a). *National criminal justice reference service*. Retrieved October 12, 2006 from <http://www.ojp.usdoj.gov/nij/topics/forensics/dna/convicted/welcome.html>.
- U.S. Department of Justice Office of Justice Programs. (2006b). *National criminal justice reference service*. Retrieved October 12, 2006 from <http://www.ojp.usdoj.gov/ovc/publications/factsheets/justforall/content.html>.
- U. S. Department of Justice. (2004). *National protocol for sexual assault medical forensic examinations*. <http://www.ncjrs.org/pdffiles1/ovw/206554.pdf>.
- The White House. (January 5, 2005). *President signs H.R. 3402, the "Violence Against Women and Department of Justice Reauthorization Act of 2005"*. Press Release.

Appendix A: Methodology

The research question for this study was: What are the enhancements (including and beyond the mandated NYS protocol) that hospital EDs in New York City have made for treating patients reporting sexual assault?

One of the goals of the Alliance is to improve the care that sexual assault survivors receive in New York City so that every survivor has access to the care they need. Knowing the current state of care will allow the Alliance to help make improvements by leveraging more financial support for EDs and by providing trainings for hospital personnel on topics related to the care of sexual assault survivors.

Survey Development

The survey questions were developed by examining several protocols and resources for the acute care of sexual assault survivors including:

1. NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault,
2. The New York State Sexual Assault Reform Act (SARA), Sexual Assault Forensic Examiner (SAFE) Program from the New York State Department of Health (appendix in the NYS protocol),
3. The U.S. Department of Justice's National Protocol for Sexual Assault Medical Forensic Examinations,
4. New York State Public Health Law; Section 2805-i; Treatment of sexual offense patients and maintenance of evidence in sexual offense, including Sections 2805-l (4-b) and 2805-l (5); Establishment of hospital-based Sexual Assault Forensic Examiner Programs (appendix in NYS protocol),
5. New York State Department of Health Guidelines for HIV post-exposure prophylaxis (appendix in NYS protocol), and
6. Teenagers, Health Care and the Law: A guide to the Law on Minors' Rights in New York State published by the New York Civil Liberties Union Reproductive Rights Project.

Members of the NYS Division of Criminal Justice Services Sexual Assault Examiners Listserv were asked for ideas to help in the development of survey questions on forensic evidence collection and possible chain-of-evidence problems at the hospital end.

Once a final draft of the survey was completed and reviewed by the Research Team, the survey instrument was presented to two committees for review and comment: the Operations, Standards and Training Committee and the Criminal Justice Collaboration Project Committee. These two committees looked at the draft version of the survey in depth and were asked to provide answers to the following questions:

1. Survey quality: Does the survey cover all key topic areas related to SAFE centers? Is the length appropriate to cover all main topics? Is there anything missing that we should add?
2. Gradation of importance: Which of the topics and/or questions on the survey is the most important? Should some sections of the survey carry more weight than others? If so, which ones and why?
3. Administering the survey: We plan to have student research assistants administer the survey to a designated hospital official. Who should be the designated hospital official? Will one person be able to complete the entire survey? Will one person be willing to sit with the research assistant until the survey is completed?
4. Buy-in: How can we ensure buy-in from all hospital administrators so that we can have completed surveys for every emergency room? Will any of the questions encourage biased answers (i.e., to make the hospital look good)? How can we avoid this bias?

Comments from these two committees were incorporated into the survey draft.

Survey Pilot

Five EDs participated in the pilot of the hospital survey representing Brooklyn, Manhattan and Queens. Three of the EDs were public and two were private.

These sites went through the survey question-by-question with the interviewer and answered for their institution. Several questions also were asked about the structure of the survey including:

1. Was the terminology for the questions appropriate?
2. Were there questions I should have asked?
3. Are there any questions I can eliminate?
4. Did any of the questions seem confusing or inappropriate?
5. Do you have any ideas of a second respondent who is not in an administrative position that we could also give the survey to? (This role should be similar across all hospitals.)

The survey took approximately 30 minutes for the respondents to complete. Changes and suggestions were incorporated into the final draft of the survey.

The Alliance's Research Advisory Committee also reviewed the survey drafts and provided comments that were incorporated into the final survey.

Sampling

The universe of hospital EDs in NYC was used as the sample framework. Using the EMS ambulance directory from 2004 and cross-checking with the NYC Department of Health and Mental Hygiene's hospital emergency department list, the final sample size was 64 EDs. Veterans' Hospitals were included, as they provide acute medical care. One

hospital emergency department was excluded from the final sample size as it had closed down recently, making the final sample size 63 EDs.

A research assistant from John Jay College of Criminal Justice was trained to conduct in-person or telephone interviews with the survey. All EDs were notified of the survey by initial letters and were contacted via phone and email by the Research Assistant. When designing the survey, there was a concern about whom to interview. It was felt that administrator responses might be different from examiner responses, and the Research Team was uncertain if one respondent would be able to answer all of the questions. Thus, two respondents from each ED were interviewed, one administrator and one provider.

The first survey was conducted with either the Emergency Department Director or the SAFE Medical Director or Coordinator. Upon completion of the first interview, the respondent was asked for the name and contact information of the second, provider respondent. To ensure comparability across hospitals, a random day of the week and hour of the day were drawn separately from a hat to help identify provider respondents. Administrator respondents were asked to provide the name and contact information for the person that was working the previous Tuesday at 8pm who would have conducted an exam if a survivor had come into the ED at that time. The provider was then contacted to complete the same survey.

The administrator responses have been used throughout the report for several reasons: 1) there was a larger sample size with administrator respondents (39 versus 23 providers) and 2) t-tests have indicated few variables for which administrator and provider responses were statistically significantly different (table 1). Providers were less likely to know the answers to certain questions, such as whether community outreach was conducted, whether there was a specific protocol for working with victims who are Mentally Retarded or Developmentally Disabled (MRDD) and whether they were able to conduct long-term follow up. Both the community outreach and the long-term follow-up may be outside of the purview of the provider's job.

Table 1: Comparison of Administrator and Provider Responses

Question	Administrators (n=23) % (n)	Provider (n=23) % (n)	t-test (n=23) (95% CI)
Participate in interdisciplinary taskforce? <i>Yes</i> <i>I don't know</i>	68.4% (13/19) —	63.6% (14/22) 31.8% (7/22)	2.73** [-3.43, -.47]
Community Outreach in the last 6 months? <i>Yes</i> <i>I don't know</i>	73.7% (14/19) —	22.7% (5/22) 36.4% (8/22)	3.95*** [-4.10, -1.28]
Do you have a specific protocol for treating MRDD patients? <i>Yes</i> <i>I don't know</i>	60.9% (14/23) —	34.8% (8/23) 21.7% (5/23)	2.68** [-2.77, -.35]
Do you check-in with patients regarding their referrals?	77.3% (17/22)	27.3% (6/22)	3.74*** [-.769, - .231]
Are you able to conduct long term follow-up? <i>Yes</i> <i>I don't know</i>	31.8% (7/22) 4.5% (1/22)	26.1% (6/23) 26.1% (6/23)	2.00** [-2.72, .022]

** significant at the .01 level

*** significant at the .001 level

Some hospitals have more than one ED in different locations across the City. It is important to note that the sample was based on EDs, not hospitals. The Research Assistant followed up with non-repondents at least five times. Due to the chaotic nature of EDs and quick turnover, it was difficult to gather survey interviews from all administrators.

Table 2: Emergency Department Survey Response Rates by Borough

	Response Rate % (proportion)
Total Sample	62% (39/63)
Bronx	40% (4/10)
Brooklyn	66.6% (12/18)
Manhattan	73.6% (14/19)
Queens	61.5% (8/13)
Staten Island	33.3% (1/3)
Public Hospitals	83.3% (10/12)
Private Hospitals	57% (29/51)

Data was collected for eight months from April 2005 to December 2005. A total of 39 hospital EDs completed the survey. Twenty-three hospital EDs completed both the administrator and provider surveys. The total survey response rate for NYC EDs was 62% (Table 2). This is comparable to a national study with a 66% response rate on a mail survey to Sexual Assault Nurse Examiner programs (Ciancone et al. 2000). Although in person administered surveys have higher response rates, the lower response rate in this sample is due to the difficulty tracking down hospital administrators and providers given the nature of their mobile work (i.e. they are not typically in an office with a computer and phone). Many administrators and providers indicated initial willingness to take the survey, but due to time constraints and difficulty in setting up interviews, they were not able to complete the survey within the study timeframe.

Public hospitals had twice the response rate of private hospitals (83.3% versus 46%). As the findings demonstrate, significant strides have been made for treating sexual assault patients in public hospitals. This could impact response rates. EDs that have established programs or that have made enhancements may have been more likely to participate in the survey for two reasons: 1) there is a designated point person for the SAFE program in

the hospital who might have more time to participate in a survey that is focused on the treatment of sexual assault patients, and 2) they provide more services and are thus more open about the services they provide.

The response rate for Certified SAFE Centers of Excellence for this study was 100%. Thus, we can safely assume that the remainder of emergency departments are non-SAFE and do not offer comprehensive services for sexual assault patients (not including the six additional EDs that have been certified as of December 2006).

The data were analyzed using SPSS 11.5 for Windows. Independent t-tests were used to test the difference in means and the significance level is reported at the .05, .01 or .001 levels as indicated in the report. One-way ANOVA was used to test difference between borough means (Manhattan, Brooklyn and Queens). Further examination of differences was conducted using Tukey's Ad hoc comparison with equal variances assumed.

Appendix B: Survey Instrument

* This survey is copyrighted. Please do not replicate the survey in whole or part without prior permission from the New York City Alliance Against Sexual Assault (contact research@nycagainstrape.org)

Satisfaction with Services in New York City

This is a non-judgmental, confidential survey to capture the procedures followed by hospitals when treating a sexually assaulted patient. Only the researchers will know the hospital's name. The hospital's name will not be named in any published or non-published reports. We are hoping to use this data to advocate for increased funding and training for hospital EDs to treat sexual assault patients.

SECTION 1: SAFE PROGRAMS

1. Does your hospital have a Sexual Assault Forensic Examiner's Program certified by the Department of Health as a Center of Excellence?
☐ Yes ☐ No ☐ I don't know
2. Does your hospital incorporate a protocol (similar to a Department of Health Sexual Assault Forensic Examiner's Program) for treating patients reporting a sexual assault?
☐ Yes ☐ No **(Skip to #7)**
3. How many years has the SAFE program been in place at your hospital?
☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-5 years
☐ More than 5 years
☐ I don't know
4. Does your SAFE program participate in an interdisciplinary taskforce that includes criminal justice and rape crisis center staff?
☐ Yes ☐ No ☐ I don't know

5. If Yes, how often, on average?
☐ Every month ☐ Every 2-6 months
☐ Every 6-12 months ☐ Every year
☐ Other (specify)
6. In the last six months, has your SAFE program done any outreach in the community?
☐ Yes ☐ No ☐ I don't know

SECTION 2: STAFFING

7. Does your emergency department have in-house Sexual Assault Forensic Examiners?
☐ Yes ☐ No **(Skip to #17)**
8. What is the role of the SAFE coordinator?
☐ Administrative
☐ SAFE Examiner
☐ Both
☐ Other
9. How many Sexual Assault Examiners work at your hospital?
_____ (fill in the blank)
10. I understand many examiners have received the 5-day training but are still going through their preceptorship with the goal of applying for NYS DOH certification. How many SAFE examiners in your program have earned NYS DOH certification?
_____ (fill in the blank)
11. How does your organization ensure ongoing learning or training for SAFE's?

12. We understand that there may be a high turnover for SAFE's. How do you retain SAFE's?

- ☐ Monthly meetings
☐ Competitive salary
☐ Other _____

13. Does your emergency department have an on-call schedule for Sexual Assault Examiners?

- ☐ Yes ☐ No

14. Does your emergency department have a back-up on-call schedule for Sexual Assault Examiners?

- ☐ Yes ☐ No

15. What is Plan B if there is no on-call or backup on-call staff?

16. Do all doctors and nurses in the emergency room, regardless if they are part of the SAFE program, receive an orientation to the SAFE program?

- ☐ Yes ☐ No

SECTION 3: SART

17. Does your emergency room department participate in a Sexual Assault Response Team (SART) program?

- ☐ Yes ☐ No **(Skip to Question 20)**

18. On average, how long does it take the SART to arrive at the hospital once they are called?

- ☐ 1–15 minutes
☐ 16–30 minutes
☐ 31–45 minutes
☐ 46–60 minutes
☐ 1–2 hours
☐ more than 2 hours

19. How many years has the SART program been in place at your hospital?

- ☐ Less than 1 month
☐ 1–3 months
☐ 3–6 months
☐ 6–12 months
☐ more than 1 year

20. How many SAFE's are available through the SART program? _____

SECTION 4: VICTIM ADVOCATES

21. Does your Emergency Department use victim advocates?

- ☐ Yes ☐ No **(Go to Question 26; skip 27)**

22. Are these victim advocates hospital social workers, other hospital staff, rape crisis advocates, or a combination?

- ☐ Hospital social workers
☐ Other hospital staff
☐ Rape Crisis advocates
☐ Combination
☐ Other (specify)

23. Would you say that all, most, some or none of the victim advocates (including Social Workers) have received the 40-hour rape crisis training?

- ☐ All
☐ Most
☐ Some
☐ None
☐ I don't know

24. Does your emergency department have an on-call schedule for victim advocates?

- ☐ Yes ☐ No ☐ I don't know

25. Does your emergency department have a back-up on-call schedule for rape crisis advocates?

- ☐ Yes ☐ No ☐ I don't know

SECTION 5: TIMELY TREATMENT

26. What is the average time for a sexual assault patient to be in the waiting room before being seen by a nurse or doctor?

- ☐ 1–15 minutes
☐ 15–30 minutes
☐ 31–45 minutes
☐ 46–60 minutes
☐ more than one hour

27. I know sometimes there are circumstances beyond hospital control that delay an advocate from arriving in a timely manner. How often would you say the physical exam begins before the victim advocate is present: Always, most of the time, sometimes or never?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

28. On average, how long does it take the on-call Sexual Assault Examiner or doctor who handles sexual assault cases to arrive at the hospital once they are called?

- ☐ 1–15 minutes
☐ 16–30 minutes
☐ 31–45 minutes
☐ 46–60 minutes
☐ 1–2 hours ☐ more than 2 hours

29. What is the average length of stay in the ER?

- ☐ 0–2 hours
☐ 2–4 hours
☐ 4–6 hours
☐ More than 6 hours
☐ I don't know

30. How long does it usually take to do the exam once the SAFE arrives?

- ☐ 0–1 hours
☐ 1–2 hours
☐ 2–3 hours
☐ More than 3 hours
☐ I don't know

SECTION 6: SPACE

31. Do you have a private room with a door designated for patients reporting sexual assault?

- ☐ Yes ☐ No ☐ I don't know

32. How often would you say that patients reporting sexual assault are seen in a private area of the hospital: Always, most of the time, sometimes or never?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Never
☐ I don't know

33. Does this private room have a shower?

- ☐ Yes ☐ No ☐ I don't know

34. If No, is there a shower available near the private room?

- ☐ Yes ☐ No ☐ I don't know

35. Is the private room or area handicap accessible?

- ☐ Yes ☐ No ☐ I don't know

SECTION 7: SPECIALIZED EQUIPMENT

36. Does your emergency department have a dedicated Colposcope to use for patients reporting sexual assault?

- ☐ Yes ☐ No ☐ I don't know

37. Does this Colposcope have the ability to photo-document?

- ☐ Yes ☐ No ☐ I don't know

38. Does your emergency department have a camera to photograph injuries?

- ☐ Yes ☐ No ☐ I don't know

39. If Yes, what type of camera?

- ☐ Digital
☐ 35mm
☐ Polaroid
☐ Other

40. Does the program use a ruler or scale (such as a quarter in the picture for reference) for measurement reference for injury documentation?

- ☐ Yes ☐ No ☐ I don't know

41. Does the program routinely label photos with the patient name or ID number and date?
☐ Yes ☐ No ☐ I don't know
42. Is there a standard procedure in place regarding photo documentation (i.e. who develops, where they are placed, how they are stored.)
☐ Yes ☐ No ☐ I don't know
43. Does your program use Toluidine Blue for injury detection?
☐ Yes ☐ No ☐ I don't know
44. Does your program have an ultraviolet light?
☐ Yes ☐ No ☐ I don't know
45. Does your program have swab dryers?
☐ Yes ☐ No ☐ I don't know
46. If No, what do you use to dry swabs?

SECTION 8: TREATMENT

47. We know that most hospitals have general guidelines for treating MRDD patients. Does your emergency department have a specific protocol on how to obtain consent from mentally retarded or developmentally disabled patients presenting for sexual assault?
☐ Yes ☐ No ☐ I don't know
48. Does your emergency department have a protocol on how to obtain consent from patients presenting for sexual assault who are under the influence of drugs or alcohol?
☐ Yes ☐ No ☐ I don't know
49. What determines using a child or adult protocol?
☐ Age ☐ Maturity ☐ Other
50. Is there a minimum age for using an adult protocol?
51. Would you say that replacement clothing is always, most of the time, sometimes or never available to patients reporting sexual assault in your emergency department?
☐ Always
☐ Most of the time
☐ Sometimes
☐ Never
52. Would you say that Crime Victims Board claim forms are always, most of the time, sometimes or never available in the emergency department?
☐ Always
☐ Most of the time
☐ Sometimes
☐ Never
53. Does your emergency department have access to 24-hour translation services?
☐ Yes ☐ No ☐ I don't know
54. If yes, do you use a person or a phone translation system?
☐ Person ☐ Phone ☐ Both
55. Does your emergency department routinely provide patient literature on counseling services for those who have been sexually assaulted?
☐ Yes ☐ No ☐ I don't know
56. Is the counseling services literature translated into any languages other than English?
☐ Yes ☐ No ☐ I don't know
- If yes, what languages:**
57. Does your emergency department give patients reporting sexual assault written information about emergency contraception?
☐ Yes ☐ No ☐ I don't know

58. Is the emergency contraception literature translated into any languages other than English?

☐ Yes ☐ No ☐ I don't know

If yes, what languages:

59. Is the patient given a pregnancy test, where applicable?

☐ Yes ☐ No ☐ I don't know

60. Is the patient reporting a sexual assault provided with emergency contraception always, most of the time, sometimes or never, provided that the patient is not already pregnant?

☐ Always
☐ Most of the time
☐ Sometimes
☐ Never

61. On average, does the patient obtain the emergency contraception directly from the health staff, at an in-house pharmacy or at an outside pharmacy?

☐ From health staff
☐ At in-house pharmacy
☐ At outside pharmacy

62. Does your emergency department hand out written information about STIs and Hep B?

☐ Yes ☐ No ☐ I don't know

63. Is the STI literature translated into any languages other than English?

☐ Yes ☐ No ☐ I don't know

If yes, what languages:

64. What STIs are routinely tested for when a patient is reporting a sexual assault?

(See Comprehensive Sexual Assault Assessment Form)

65. Is the patient provided with prophylaxis for STDs and Hepatitis B, where medically feasible?

☐ Yes ☐ No ☐ I don't know

66. Does your emergency department hand out written information about HIV Post-Exposure Prophylaxis (HIV PEP) for non-occupational exposure?

☐ Yes ☐ No ☐ I don't know

67. Is the HIV PEP literature translated into any languages other than English?

☐ Yes ☐ No ☐ I don't know

If yes, what languages:

68. Is the patient provided with prophylaxis for HIV PEP, where medically feasible?

☐ Yes ☐ No ☐ I don't know

69. On average, are follow-up appointments made always, most of the time, sometimes or never for the HIV PEP?

☐ Always
☐ Most of the time
☐ Sometimes
☐ Never

70. Does your emergency department routinely give verbal information to patients reporting sexual assault about reporting to the police?

☐ Yes ☐ No ☐ I don't know

SECTION 9: FOLLOW-UP SERVICES

71. On average, do you refer sexual assault patients to a rape crisis program for follow-up counseling?

☐ Yes ☐ No **(Go to Q. 73)**

72. Is this rape crisis counseling referral for:

☐ An in-house rape crisis program (Skip to #75)
☐ An in-house social work program
☐ A local rape crisis program. **(Skip to #75)**

IF THEY ANSWER THAT THEY REFER TO AN **IN-HOUSE SOCIAL WORK PROGRAM**:

73. Is there a local rape crisis program near to the hospital that you know of?

☐ Yes **(Skip to #76)** ☐ No

74. IF ANSWER NO: If there was a local rape crisis program available would you refer patients to this program?

☐ Yes ☐ No

75. Do you routinely 'check in' with patients after they leave the hospital regarding their referrals?

☐ Yes ☐ No **(Skip to #78)**

IF YES:

76. How long after they leave the emergency department do you check in?

- ☐ Within 24 hours
☐ Within 48 hours
☐ Within 1 week
☐ Other

We know that for many hospitals, the 'check-in' is the only opportunity for follow-up with the patient.

77. Is your hospital able to conduct any long-term follow-up with patients (i.e. anything after 1 month?)

☐ Yes ☐ No **(Skip to #79)**

IF YES:

78. How long after they are discharged from the ED do you follow-up? _____

SECTION 10: QUALITY OF EVIDENCE COLLECTION

79. Does your emergency department use a standardized comprehensive care form to document evidence collection and injury?

☐ Yes ☐ No ☐ I don't know

80. Some hospitals use the NYS Protocol comprehensive care form for documenting injuries, while other hospitals make their own specific injury documentation record. Do you use the NYS Protocol example SAFE form or your own?

- ☐ SAFE's
☐ Hospital's (Ask for a copy of their form.)
☐ I don't know

81. Does your emergency department use the New York State Sexual Offense Evidence Collection Kit?

☐ Yes ☐ No ☐ I don't know

82. Do you follow all the steps listed in the kit?

☐ Yes **(Go to #84)** ☐ No

83. If no, which steps do you not follow and why?

84. Does your emergency department use the New York State Drug-Facilitated Sexual Assault Kit?

☐ Yes ☐ No

85. Do you follow all the steps listed in the kit?

☐ Yes **(Go to #87)** ☐ No

86. If no, which steps do you not follow and why?

87. Do you have the capacity to store DFSA kits in locked, refrigerated storage?

☐ Yes ☐ No ☐ I don't know

88. Does your emergency department keep a record log for the release of forensic evidence to law enforcement? (Clothing, kits etc.)

☐ Yes ☐ No ☐ I don't know

89. Are forensic evidence kits stored in locked cabinets?

☐ Yes ☐ No ☐ I don't know

90. On average, how long do you store forensic evidence kits?

- ☐ Less than 30 days
☐ 1–3 months
☐ 4–6 months
☐ 7–12 months
☐ 1–5 years
☐ More than 5 years

91. Does your emergency department contact victims prior to throwing away the forensic evidence kits?

- ☐ Yes ☐ No ☐ I don't know

SECTION 11: SAFE DISCHARGE

92. Does a staff member of the emergency department inquire about the victim's discharge destination always, most of the time, sometimes or never?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Never
☐ I don't know

93. Will your emergency department allow an overnight stay of a patient reporting sexual assault until they can secure a safe location?

- ☐ Yes ☐ No ☐ I don't know

94. Does your emergency department routinely secure transportation for patients reporting sexual assault upon discharge from the hospital?

- ☐ Yes ☐ No ☐ I don't know

95. Is follow-up outreach to the patient reporting sexual assault routinely conducted the following day to ensure their safety?

- ☐ Yes ☐ No ☐ I don't know

SECTION 12: QUALITY IMPROVEMENT

96. Do you run into problems releasing information to detectives or ADAs?

- ☐ Yes ☐ No ☐ I don't know

97. If yes, what problems? How is it usually resolved?

98. Has anyone in your staff been trained to testify in a court of law about medical evidence and collection procedures?

- ☐ Yes ☐ No ☐ I don't know

99. Is there an established system for quality improvement of care specifically for treating patients reporting sexual assault?

- ☐ Yes ☐ No ☐ I don't know

100. Are chart audits routinely conducted on patients reporting sexual assault?

- ☐ Yes ☐ No ☐ I don't know

101. To your knowledge, has your emergency department/SAFE program conducted a satisfaction survey for patients reporting sexual assault in the last two years?

- ☐ Yes ☐ No ☐ I don't know

102. To your knowledge, does your emergency department/SAFE program collect any additional data (beyond m-stat; complaint codes; drg diagnostic related group codes) about patients reporting sexual assault?

- ☐ Yes ☐ No ☐ I don't know

103. If Yes, explain.

104. Is there anything else you would like to tell me about any of enhancements made in your ED for treating patients reporting sexual assault?

Thank you for taking time to complete this survey.

Appendix C: Timeline of Legislation and Events around Acute Care for Survivors of Sexual Assault in NYC and NYS

1966 Crime Victim's Board Compensation Established

The New York State Crime Victims Board was created under Article 22 of the Executive Law to compensate innocent victims of crime for unreimbursed out-of-pocket expenses. The board provides substantial financial relief to victims of crime and their families by paying crime-related expenses (NYS CVB, 2006a).

1975 New York Rape Shield Law, Criminal Procedure Code 60.42

Provided for a general rule prohibiting evidence of a victim's prior sexual conduct, with exceptions in certain cases. The statute also provides some procedural protections for the victim and a right to be heard in the proceedings (NYS Assembly, 2006a).

1987 The first specialized sexual assault examiner program in New York City developed as a pilot program at NYC's Bellevue Hospital.

1989 The Governor's Task Force on Rape and Sexual Assault was established by executive order for the purpose of developing a standardized best practice protocol for care of sexual assault patients.

1989 Interviewing in Private Settings, Executive Law Amendment, Article 23, Section 642.2-a

Requires police departments and district attorneys' offices to provide private settings for interviewing victims of sex offenses (NYS OAG, 2006).

1990 Governor Cuomo's administration approved funding for manufacturing sexual assault evidence kits and training to accompany the best practice protocol.

1991 Rape Crisis Center Notification, Executive Law Amendment, Article 23, Section 641.1

Requires police departments to provide victims of sex offenses with written notice of the name, address and telephone number of the nearest rape crisis center (NYS OAG, 2006).

1993 Rape Crisis Counselors' Confidentiality, Civil Practice Law and Rules, Article 45, Section 4510

Established confidentiality privileges for rape crisis counselors (NYS OAG, 2006).

1993 DCJS developed the Sexual Offense Evidence Collection (SOEC) kit to create a standard protocol for hospital personnel to follow in the collection of evidence from those involved in any criminal incident involving a sexual offense. It was established through the cooperative efforts of the State Crime Laboratories, the Division of Criminal Justice Services, the State Police and the Department of Health (NYS DCJS, 2005).

1994 Violence Against Women Act (VAWA)

Passed under the larger Omnibus Crime Control Act, this multi-faceted statute addressed the inequality that women victims of violence encounter in state justice systems. The statute provided funding to states for criminal law enforcement against perpetrators of violence, and for a variety of other services for victims of sexual assault (Sklar & Lustig, 2001).

1994 Public Health Law, section 206(15) Title 10, Subpart 69-5

Established approval guidelines for rape crisis programs for the purpose of rape crisis counselor certification (NYS DOH, 2006b).

1994 DNA Databank

Legislation enacted that authorized the collection of DNA samples from all persons convicted certain felonies including murder, assault, and sex offenses in New York State (NYS Division of State Police, 2006).

2000 DNA Analysis Backlog Elimination Act, H.R. 4640

Authorized the appropriation of \$170 million over fiscal years 2001 through 2004 for grants to states to increase their capability to perform DNA analyses and mandates the collect of DNA samples of violent and sexual offenders (U.S. Department of Justice, 2006a).

2001 Sexual Assault Reform Act (SARA)

First comprehensive reform to Article 130, the article in the penal law defining sex crimes, since it was adopted in 1965. The law defines what constitutes lack of consent and sexual assault (New York City Alliance Against Sexual Assault, 2005b).

2003 Local Law No. 19

Law requires that the Department of Health must make emergency contraception available at every health care facility operated or maintained by the department (NYC Council, 2007).

2003 Local Law No. 25

Law enacted requiring pharmacies in New York City to post signs regarding the sale of emergency contraception (NYC Council, 2006b).

2003 Local Law No. 26

Law states that New York City will only contract with hospitals that provide emergency contraception to rape victims when medically appropriate, and requires hospitals to provide victims with information about emergency contraception (NYC Council, 2006a).

2003 Local Law No. 75

Created to eliminate and prevent employment and housing discrimination for victims of domestic violence, sex offenses and stalking (NYC Council, 2006c).

2003 Forensic Payment Act, Executive Law 631.13

Crime Victims Board began reimbursing service care providers for sexual assault exams. Previously, sexual assault victims were required to pay for their own exam (New York City Alliance Against Sexual Assault, 2005b).

2003 DCJS released a new Drug Facilitated Sexual Assault (DFSA) evidence collection kit to be used in conjunction with the Sexual Offense Evidence Collection kit in cases in which it is suspected that drugs were used to facilitate the assault (NYS DCJS, 2005).

2003 Sexual Assault Reform Act Amendments

A new provision to SARA required hospitals that treat rape victims to provide information on emergency contraception. If the victim requests it, the hospital must provide EC (NYS CVB, 2006c).

2004 Mayor Bloomberg announced a pilot program for the first Sexual Assault Response Team (SART) that will provide forensic and counseling services to rape victims within one hour of arrival at public hospitals in the Bronx (NYC.gov, 2004).

2004 The DOH revised Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault (NYS DOH, 2004).

2004 Justice for All Act, Public Law 108-405

Act created to protect crime victims' rights, eliminate the substantial backlog of DNA samples collected from crime scenes and convicted offenders, and improve and expand the DNA testing capacity of federal, state, and local crime laboratories (U.S. Department of Justice, 2006b).

2005 Violence Against Women and Department of Justice Reauthorization Act, H.R. 3402

Enacted to provide grants to enhance judicial and law enforcement tools to combat violence against women, and improve services for victims of domestic violence, sexual assault, and stalking (The White House, 2005).

2005 NYS Public Health Law; Section 2805-P

Allows information to be provided in emergency rooms and requires emergency rooms to dispense emergency contraception upon request (NYS DOH, 2006b).

2005 The New York State Department of Health AIDS Institute (NYSDOH AI) published revised guidelines that address HIV post-exposure prophylaxis (PEP) following sexual assault. NYSDOH recommends that survivors of sexual assault be treated in an emergency department or equivalent healthcare setting where all appropriate medical resources are available as needed (NYS DOH, 2006b).

2006 Mayor Bloomberg expanded the SART program to hospitals in Manhattan, Brooklyn, and Queens, based on the success of the program in the Bronx (NCDSV, 2006).

2006 DNA Databank Expansion

Legislation passed to expand the DNA databank to roughly triple its size. The criminal DNA database will encompass all persons convicted of felonies and 18 key misdemeanors (NYS Assembly, 2006b).

2006 Eliminating Statute Of Limitations for Sexual Assault Crimes

Eliminated the statute of limitations for the prosecution of, or civil claim against, an action relating to rape in the first degree, a criminal sexual act in the first degree, an aggravated sexual abuse in the first degree, and a course of sexual conduct against a child in the first degree (NYS Assembly, 2006a).

We Need Your Help ► Because Sexual Violence Is Still a Problem.

The New York City Alliance Against Sexual Assault develops and advances strategies, policies and responses that prevent sexual violence and limit its destabilizing effects on victims, families and communities. As the only sexual violence organization in the country conducting primary research on sexual violence, we are in a unique position to raise public awareness and

create sustainable change. Our work is made possible by the generous contributions of people like you; people who share the commitment of engaging all communities in addressing sexual violence. Together we can ensure survivors of sexual violence receive the best care and dare to envision a world without sexual violence. All we need is you! Please give today.

Please select how you would like to direct your gift:

- ☐ **Give to the Alliance / Community Fund**
- ☐ Innovative Research
- ☐ Immigrant Women
- ☐ Youth
- ☐ Survivor Access to Best Care
- ☐ Training and Education
- ☐ Sexual Violence Resource Leader
- ☐ Legislative Advocacy
- ☐ Community Organizing
- ☐ SAYSO!

Please select your gift amount:

- ☐ \$25 ☐ \$50 ☐ \$100 ☐ \$250
- ☐ \$500 ☐ \$1,000 ☐ Other \$ _____

First Name _____

Last Name _____

Address _____

City _____

State _____

Zip _____

Daytime Phone _____

Email Address _____

Payment Method:

- ☐ Check or money order payable to the
New York City Alliance Against Sexual Assault

Credit card (check one)

- ☐ MasterCard ☐ VISA ☐ Amex ☐ Discover

Card number _____

Expiration Date _____

Today's Date _____

Name on Card _____

Billing Address ☐ same as opposite column

Address _____

City _____

State Zip _____

I would like my contribution to be in honor of: _____

I would like my contribution to be in memory of: _____

Fax your completed form to **212.229.0676**
or mail it to:

New York City Alliance Against Sexual Assault
27 Christopher Street, 3rd Floor
New York, NY 10014

To learn more about the Alliance or to donate online,
please visit **www.nycagainstrape.org**



New York City Alliance
Against Sexual Assault

2005–2007 NYC Alliance Against Sexual Assault

BOARD OF DIRECTORS

Jennifer Mercurio, Board Chair

Mary Anderson

Madeline Bryer

Larry Busching

Louise Friedman

Erica Garcia

Herbert Goodfriend

Nathan Lubow

Benedict Monachino

Kristina Pappa

Mel Schneiderman

Shirley Traylor

Hope Wachter

Susan Xenarios

NYC Alliance Against Sexual Assault

PROJECT STAFF

Deborah Fry: Research Director

Sara Kane: Research Intern

Tamara Pollak: Training and Education Director

Jennifer Tierney: Communications Director

Katie Bower: Social Work Policy Intern

Lauren Mills: Social Work Policy Intern

CONSULTANT

Scott Santoro / Worksight: Graphic Design



**New York City Alliance
Against Sexual Assault**

NYC Alliance Against Sexual Assault
27 Christopher Street
3rd Floor
New York, NY 10014
(212) 229-0345 phone
(212) 229-0676 fax
research@nycagainstrape.org
www.nycagainstrape.org

Publication 6

Fry, D. (2007). *A Room of Our Own: Survivors Evaluate Services*. New York City Alliance Against Sexual Assault: New York.

Copyright permission obtained from the NYC Alliance Against Sexual Assault to use and archive this research report within this PhD by Publications thesis.

APRIL 2007

A Room of Our Own: Sexual Assault Survivors Evaluate Services

**A Research Report
from the New York City Alliance
Against Sexual Assault**



A Room of Our Own: Sexual Assault Survivors Evaluate Services

By Deborah Fry



**New York City Alliance
Against Sexual Assault**

Published by the
New York City Alliance Against Sexual Assault

27 Christopher Street, 3rd Floor
New York, NY 10014
Phone: 212.229.0345
Fax: 212.229.0676
research@nycagainstrape.org
www.nycagainstrape.org

First printing: April 2007
Editor: Jennifer Tierney
Report design: Scott Santoro, Worksight

Copyright © 2007
New York City Alliance Against Sexual Assault
All rights reserved
Printed in the United States

Foreword

Victim-centered care after an assault is vital for recovery from the trauma inflicted by sexual violence. Services that provide important medical and psychological care can start the recovery process by strengthening victims to attend to their immediate needs. Furthermore, a survivor has the option of reporting the assault to law enforcement and working with the criminal justice system to hold the perpetrator accountable. The New York City Alliance Against Sexual Assault holds a value that it is crucial to ask survivors what they thought of the care they received and how they think we can improve the system to better meet their needs.

A Room of Our Own: Survivors Evaluate Services reveals in their own voices the experiences adult survivors have when they seek care after a sexual assault. Many of the survivors who participated in this study talked about their experiences of not being believed, not being treated in a caring manner or not being heard in their interactions with service providers after an assault. When compared to those survivors who felt well taken care of, we can no longer tolerate inadequate care. While there are many model programs in NYC to work with sexual assault survivors such as the Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Response Team (SART) programs in emergency departments, the city's rape crisis programs, the NYPD's Special Victims Division and the Sex Crimes Bureaus at each of the five District Attorney's offices, there is still much work that needs to be done to ensure that *all* survivors have access to the best care in New York City.

The New York City Alliance Against Sexual Assault has played a leadership role to ensure that all New Yorkers have access to quality sexual assault services and interventions, should they need them. We are one of two NYS Department of Health-certified SAFE training program in the NYC area and

we train close to 200 health professionals a year to provide specialized, quality care to survivors in the acute care setting. We also provide training for rape crisis counselors through our Rape Crisis Training Institute and coordinate a Criminal Justice Collaboration Project to work with our colleagues in the law enforcement and criminal justice sectors.

The Alliance's innovative research seeks to provide baseline evidence regarding the treatment of sexual assault survivors in NYC with one goal in mind to improve care. The companion research report *How SAFE is NYC?: Sexual Assault Services in Emergency Departments* documents what is and is not being done for survivors in the acute care setting. Together these two reports highlight the tremendous strides that NYC has made to improve services and the work that still needs to be done to ensure that all survivors, no matter what borough, no matter what age, no matter what sexual orientation or physical ability, have access to the best services available.

We hope you will take the findings of these reports to heart and join us in our goals.



Harriet Lessel, Executive Director
New York City Alliance Against Sexual Assault
June 2006

Acknowledgements

This study was conducted through the Research Department of the New York City Alliance Against Sexual Assault led by Deborah Fry (Research Director). The online component of this study was developed by Sam Nelson (Web Manager) for the Alliance.

We would like to thank all the women and men who participated in this study. We hope your courage in participating and allowing us to learn from your experiences will help improve the system for others. We would also like to thank the women who participated in the focus groups at the beginning of this project to help design the survey, your input was very helpful and much appreciated. Much gratitude goes to the many stakeholders and survivors who reviewed the various survey drafts and provided incredible input for improving the survey.

A special thanks goes to the Survivor Survey Outreach Committee, a group of dedicated volunteers who sought to spread the word high and low about this research project across NYC: Keri Walden, Lynn Frederick Hawley, Vivian Lew, Linda Juste, Traci Shoemaker, Christine Borges, Melanie Lynn and Mandi Larsen. A big thank you to Christy Banister, a dedicated volunteer who finalized the references and bibliography for this report.

A warm thank you goes to the 13 participating rape crisis program sites and their staff for working with the Alliance on the often cumbersome Institutional Review Board protocols, training and data collection process. Your tireless effort to improve services for survivors is to be applauded.

The Alliance thanks the key stakeholders from the four sectors: hospital services, rape crisis programs, law enforcement and criminal justice services who met with us to review the report and provide comments and feedback.

Appreciation also goes to the 2004–2006 NYC Alliance Against Sexual Assault Research Advisory Committee for their guidance on the Alliance's research projects and their comments on this report: Cari Olson, MPH (Director of Research, Injury Epidemiology Unit, Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene); Catherine Stayton, MPH, DrPH (Director of the Injury Epidemiology Unit, Bureau of Epidemiology Services at the NYC Department of Health and Mental Hygiene); Larry Busching (Chief, Family Court Division of the NYC Law Department and a member from the Alliance's Board of Directors); Karen Terry, PhD (Deputy Executive Officer, Program of Doctoral Studies in Criminal Justice at the John Jay College of Criminal Justice); Marielis Rivera, MPH (Health Educator at the South Bronx Health Center for Children and Families); Victoria Frye, MPH, DrPH (Research Investigator at the NY Academy of Medicine); Susan Xenarios, LCSW (Director of the Crime Victims Treatment Center at St. Luke's-Roosevelt Hospital and a member of the Alliance's Board of Directors); and Donna Gaffney, MA, Msc, RN, DNSc, (Associate Professor, Seton Hall University).

Special thanks also goes to the following Alliance staff: Tamara Pollak (Training and Education Director); Jenn Tierney (Communications Director); Daisy Deomampo (Research Associate); Christine St. John (Community Organizer); Deiderie Armstrong (Assistant Director); Tamika Johnson and Tamecca Phillips (Administrative Assistants); and a special thanks to Harriet Lessel (Executive

Director) for her vision and support of this research project. Additional thanks goes to Mel Schneiderman, PhD, (member of the Alliance Board), for his thoughtful comments on the draft report. Warm thanks go to all of the Alliance's Board members who commented on the drafts of the report and thoughtfully discussed the dissemination and linkage of the report to our advocacy goals.

A big thank you goes to Dr. Rebecca Campbell who reviewed the final draft of the report. We are continually impressed and applaud your service-based research efforts to improve care and measure the outcomes of improved care for sexual assault survivors.

This research and publication was funded by grants from the New York City Council and the New York State Department of Health. The Alliance would like to thank these two funders for their contributions to defining and developing evidence-based best care for sexual assault survivors in NYC. The dissemination of this report was funded through the New York State Division of Criminal Justice Services, a leader in funding programs to improve their response to sexual assault victims in NYC.

About the Author

Deborah Fry is the Research Director at the New York City Alliance Against Sexual Assault. At the Alliance, Deborah works on citywide research projects, all geared to helping improve service delivery for survivors in NYC and evaluating current prevention and intervention programs. Current projects include this study and *How S.A.F.E. is NYC? Sexual Assault Services in Emergency Departments*. In addition to conducting primary research, Deborah also provides research technical assistance to the NYC rape crisis programs. Deborah has a Masters of Arts degree from the Maxwell School of Citizenship and Public Affairs at Syracuse University and her Masters in Public Health from Columbia University. Deborah was also a Fulbright Research Scholar from 2001 to 2002.

Table of Contents

Foreword	i	Chart 11. Percentage of Respondents Who Received Information About the Criminal Justice Process	46
Acknowledgments	ii	Table 1. Overview of Survivor Recommendations	52
Executive Summary	1	Table 2. Sample Distribution	54
Chapter 1. Introduction	5	Survivor Voices	
Chapter 2. Hospital Services	13	What Was the Best Thing About Going to the Hospital?	18
Chapter 3. Rape Crisis/Victim Assistance Programs	25	What Was the Worst Thing About Going to the Hospital?	21
Chapter 4. Law Enforcement	33	What Was the Best Thing About Going to a Rape Crisis Program?	28
Chapter 5. Criminal Justice	43	What Was the Worst Thing About Going to a Rape Crisis Program?	30
Chapter 6. Implications	51	What Was the Best Thing About Going to the Police?	36
Appendix A: Methodology	53	What Was the Worst Thing About Going to the Police?	40
Appendix B: Survey Instrument	59	What Was the Best Thing About Going to the District Attorney's Office?	47
References	67	What Was the Worst Thing About Going to the District Attorney's Office?	49
Charts and Tables		Quality of Care Case Studies	
Chart 1. Age When Sexual Assault Occurred	9	Providing Care to Survivors with Mental Illness	20
Chart 2. Borough of Residence, Assault and First Services Contacted	10	LGBT Survivors: Navigating Through Heterosexist Systems	29
Chart 3. Respondents (%) Referred to Other Services From First Point of Contact	11	Male Survivors of Sexual Assault: The Hidden Epidemic	39
Chart 4. All Services Contacted After Assault	11	Providing Quality Services to Survivors with Physical Disabilities	48
Chart 5. Victim Advocate Services	17		
Chart 6. Treatment by Doctor/Nurse	17		
Chart 7. Why Respondents Felt Poorly Treated at the Hospital	19		
Chart 8. Percentage of Respondents That Felt Their Rape Crisis Counselors Knew How to Help Them	27		
Chart 9. Reasons for Feeling Poorly Treated by the Police	37		
Chart 10. Satisfaction with Treatment by Uniformed and Non-Uniformed Officers	38		

Executive Summary

Every year the New York City Alliance Against Sexual Assault hosts a Sexual Assault Yearly Speak Out (SAY SO), a day-long reading of survivors' stories. SAY SO is an important event to empower survivors, to hear their stories, to get the larger NYC community to talk about sexual violence and to *change* the environment from one of tolerance to intolerance of sexual violence. The opening ceremony of the 2006 SAY SO event featured Karen Carroll, the Associate Director of the Bronx Sexual Assault Response Team. Karen, a survivor of marital rape, talked about her experiences with the hospital staff after *her* sexual assault. This experience eventually led her to become a Sexual Assault Forensic Examiner to help other survivors as they seek care after their assault.

It was a Saturday morning. I opened the bedroom door and he was standing there. In his right hand was a knife and in his left hand two black ropes. My memory of the rape is like I was a spectator. I remember thinking, 'Watch everything.' He's going to jail but I need evidence. I was lucky that the detective who showed up at the hospital was compassionate and asked appropriate questions. But I had a horrible rape exam. The doctor didn't even say hello. He walked over to the rape kit and started reading directions. I had been an ER nurse long enough to know that if you don't collect evidence the right way, it might not be used in court. I had to show the doctor how to do my rape kit.

Survivors of sexual violence can turn to a variety of services after an assault. They may seek medical care, counseling services, report the assault to the police and/or work with prosecutors on a legal case. Often survivors are treated poorly by the very systems set up to help them. Secondary victimization has been defined as the victim-blaming attitudes, behaviors, and practices engaged in by community service providers that result in additional trauma for rape survivors. Examples include asking victims how they were dressed, questioning

them about their sexual histories, asking if they were sexually turned on by the assault or encouraging them not to prosecute (Campbell et al., 1999; Campbell & Raja, 2005 as cited in Campbell 2006). Such treatment increases rape survivors' feelings of stress, guilt, depression, and distrust and reluctance to seek further help (Campbell et al., 1999; Campbell et al., 2001; Campbell & Raja, 2005 as cited in Campbell, 2006).

A recent study compared victims' accounts of what happened during service delivery with those of doctors, nurses and police officers. Police officers and doctors significantly underestimated the impact they were having on survivors. Victims reported experiencing more distress about their contacts with the medical and criminal justice systems than service providers thought they were experiencing (Campbell, 2005).

One of the main reasons for embarking on this research is to provide a forum for survivors' voices and use those experiences to start a dialogue about systems change. Having an opportunity to express one's voice is especially important after experiencing one of life's most disempowering violations—sexual violence.

The Alliance is in a unique position to conduct this research *and* implement the recommendations posed by survivors. The Alliance is one of the few survivor advocacy organizations with a strong research department. Using the public health model, the Alliance seeks to find out the 'how, where, by whom and how we can stop it' of sexual violence. The Alliance conducts this research both to inform the prevention of sexual violence but also to ensure that *all* survivors have access to the best care. Currently, we are one of two New York State certified Sexual Assault Examiner Training Programs serving the 63 emergency departments in NYC—this means that we train all the doctors, nurses, nurse practitioners and physician assistants in the city

that want to provide specialized care to sexual assault patients. The Alliance also provides trainings to all the sectors involved with responding to sexual assaults: hospitals, rape crisis programs, law enforcement, and criminal justice.

New York City offers several sources of public assistance to sexual violence survivors including: specialized hospital services including forensic evidence collection, free and confidential rape crisis counseling (both associated with hospitals and community-based programs), and specialized police and criminal justice response. This report reflects the quality of these services from the survivors' perspective.

An anonymous survey was provided to survivors of adult sexual violence (violence that occurred when they were 18 or older) who had sought services for that assault in NYC. Recruitment of participants (18 and older) for this study included the general NYC public through a web-based survey and advertising in both English and Spanish through print media and radio and through rape crisis programs. A total of 77 respondents filled out the survey; 12 of these did not meet the study criteria and were excluded from the study leaving a total sample size of 65 respondents.

With this report, the Alliance takes the evaluation of service provision to a participatory level by including feedback from the very people who use these services. It is important to include survivors' voices in this field and remember that a responsible sexual assault response includes interdisciplinary collaboration and feedback from victims. This is the *first* ever citywide report that includes the survivor perspective in both the experiences of services and also in the recommendations for service improvement. Chapter 1 defines the response to sexual violence and the services that are available to survivors in New York City and the challenges of measuring 'satisfaction' in this field. Chapter 2 describes survivors' experiences seeking hospital

care. Chapter 3 examines survivors' satisfaction with rape crisis programs. Chapter 4 examines the experiences survivors have with the police and Chapter 5 describes the interactions with the criminal justice system. Every chapter concludes with survivor recommendations for improving the city's response to sexual violence and to improve services. Lastly, Chapter 6 describes the implications of the findings and concludes with a call for dialogue and questions that should be addressed.

Key Findings:

Survivors are more satisfied with care they receive at hospitals that have a Sexual Assault Forensic Examiner (SAFE) Program.

Survivors were more likely to be satisfied with the medical care they received at the hospital if they went to a New York State Department of Health-certified Sexual Assault Forensic Examiner (SAFE) Center of Excellence. These programs were specifically developed to ensure that sexual assault survivors are provided with competent, compassionate, victim-centered and prompt medical care, while at the same time enabling forensic evidence collection and preservation if the survivor wishes at any point to go forward in the criminal justice process. As of May 2006, there were 17 SAFE Centers of Excellence among the 63 emergency departments in NYC. *Where* you go for care will likely impact the *quality* of care you receive after a sexual assault. There is, however, no communication campaign in place to let the general public know which hospitals are designated as SAFE Centers of Excellence.

Volunteer rape crisis advocates are an important component of survivor care.

The presence of a volunteer (not part of hospital staff) victim advocate had a statistically significant impact on the survivors' satisfaction with the care they received at the hospital. Survivors who had the help of a victim advocate during their hospital visit reported being 'very satisfied' or 'satisfied' with their care at the hospital more often than survivors who did not have the help of a victim advocate. The victim advocates gave survivors information about counseling and reporting to the police. Furthermore, more than three-quarters of survivors reported that the victim advocate gave them the support they needed during the hospital visit and helped explain components of the medical exam to them.

Many survivors did not receive adequate medical care and follow-up from the hospital.

Less than a third of survivors reported that their doctor or nurse asked if they had a safe place to go after leaving the hospital or made follow-up medical appointments for them. Just a little over half of the respondents reported that they were given information about HIV post-exposure prophylaxis, when appropriate, or information about sexually transmitted infections. A larger percentage (68%) of survivors reported being given information about emergency contraception, when applicable. These percentages are in contrast to what hospitals report doing in our companion piece *How SAFE is NYC? Sexual Assault Services in Emergency Departments*. In this report, *all* of the hospital representatives interviewed reported *always offering* emergency contraception and nearly all reported offering HIV post-exposure prophylaxis when indicated.

Standard of care is low for certain populations across all sectors.

Each chapter of this report highlights experiences of the substandard care received by vulnerable populations—survivors with mental illness, male survivors, disabled survivors, and lesbian, gay, bisexual and transgender (LGBT) survivors. Their experiences inform broader questions regarding quality of care. Dialogue, training, protocol development, monitoring and evaluation are needed to ensure that *all* survivors receive the best care.

Out of all the sectors, survivors were most satisfied with the care they received at rape crisis programs.

This is likely due to the fact that the mandate of rape crisis programs is to deliver victim-centered care to promote the healing and recovery from trauma after a sexual assault. Other victim services sectors may operate under different mandates (such as providing medical care, enforcing the law and ensuring community safety). Regardless of the overarching mandate, all sectors can and should utilize a victim-centered approach.

“I felt in control again, I felt like I was doing everything I could.”

—34-year-old female

Chapter 1: Introduction

Defining Sexual Violence

When we talk about *sexual violence* we mean:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or [acts] otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (World Health Organization [WHO], 2002).

For this study, we did not give survivors a set definition of *sexual assault* or *sexual violence*, instead we relied on their self-defined meaning of the word. No matter how we define it, if they sought services for the assault, they should be delivered in a sensitive and victim-centered manner.

Throughout this report we use the words *survivor* and *victim* interchangeably in order to recognize and validate the seriousness of the act against the person while at the same time focusing on the person's ability to recover from this trauma.

Defining Satisfaction with Services

Client satisfaction studies are a recognized tool to improve the quality of services. Patient or client satisfaction is increasingly highlighted as an important objective of health care and other human service sectors, a key determinant of service quality and a useful indicator of outcome (Stallard, 1996). Various researchers have viewed satisfaction as the degree of discrepancy between expectation and experience (Oliver, 1979 as cited in Stallard, 1996). This means that dissatisfaction would occur when experience fails to achieve expectations.

Other researchers, however, have viewed these models as too simplistic and focused on the concept and nature of expectations. They ask: do people have realistic expectations of services about which they have no knowledge or only limited contact? Limited knowledge about services may result in clients without standards who will perceive any

service as satisfactory. We find, however, that this is not the case when clients are asked to evaluate services after a sexual assault, since survivors are likely to be familiar with emergency hospital care, counseling, and possibly the police. It is less likely that they will have had any previous experience with the criminal justice system through the District Attorney's office.

Some current research looks at what the meaning of 'satisfaction' and 'dissatisfaction' mean and how they can be measured. A study on dissatisfaction found that the concept of 'personal identity threat' was a key variable in understanding dissatisfaction with health care. Threats to personal identity included perceptions of being dehumanized, objectified, stereotyped, disempowered and devalued (Coyle, 1999). The opposite end of the spectrum is a definition that satisfaction is 'the extent to which treatment gratifies the wants, wishes, and desires of clients' (Lebow, 1982 as cited in Stallard, 1996). Whatever the underlying theoretical models, it is clear that clients do evaluate and make judgments about the services they receive.

Most satisfaction assessments consist of a survey covering major domains of service delivery. Open-ended questions within this format elicits more critical comments, enabling analysis of both satisfaction and dissatisfaction. The current study employed the use of open-ended questions for each service sector by asking **1)** Was there anything that prevented you from going to [service sector, such as hospital, rape crisis program, police or District Attorney's office], **2)** What was the best thing about going to [service sector], **3)** What was the worst thing about going to [service sector], and **4)** What recommendation do you have to improve these services for other survivors?

Client satisfaction is a key objective for service delivery. Research has shown that if a service is unacceptable to its users, it will be under-used regardless of how effective it might be (Holland,

1983 as cited in Stallard, 1996). Satisfaction is also often used as an outcome indicator for assessing services, especially where other outcomes (such as therapeutic change) are hard to identify and quantify (Fitzpatrick, 1991 a; Stallard, 1994 as cited in Stallard, 1996). One strength of satisfaction studies is that they map out service quality over time to see if interventions have been effective. Thus, it is possible that this study could serve as a baseline, with future studies conducted in five to ten years after the survivor recommendations are implemented.

When is the most optimal time to assess satisfaction with services: directly after they are received, a short time later, or two to three years later? This is a key question for researchers. The current study did not set a time limit for when services were accessed. While the majority of respondents accessed services within the last year, there are a few respondents who accessed services more than a decade ago. A primary objective of this study was to provide survivors with a forum to discuss their experience of services for sexual assault since each one can provide valuable lessons and learning opportunities for service providers in this field. Further, smaller sample sizes are the norm in this field of research, and it was felt if the timeframe was limited that fewer respondents would have the opportunity to give feedback.

One drawback to having an open timeframe is the increased probability that changes in service provision have occurred. This, however, seems to affect the analysis little because very few respondents sought services outside of the last three years and upon closer examination, the levels of satisfaction varied very little between those who sought services more than three years ago versus those who experienced services within the last three years.

The issue of whether questionnaire respondents are more or less satisfied than non-respondents has received little attention and yet is of central importance to analyzing results and implementing service change. Due to the length of the survey and the subject matter, it is hypothesized that those who were either very satisfied or very dissatisfied were more likely to fill out the survey than those

who were not at either extreme. Thus, the levels of 'satisfaction' and 'dissatisfaction' may be underestimated in the current study.

What is an acceptable level of satisfaction? Studies have found that 90% satisfaction is a good criterion for overall satisfaction; this criterion might drop to 80% when evaluating specific components of service delivery (Bucknall, 1994; Godin et al., 1987; Gowers & Kushlick, 1991; Stallard et al., 1992 as cited in Stallard, 1996). This means that in other studies an expected dissatisfaction percentage is approximately 10-20% of users. Focusing on those aspects with the highest levels of dissatisfaction is often more effective for systems change.

Satisfaction studies inform service improvements. We hope our findings serve to transform services for survivors of sexual violence into a more victim-centered approach. Key stakeholders from each of the service sectors were involved in the conceptualization and design of the survey. They also provided feedback and comments on this study. Chapter 6 makes a call for dialogue based on the findings and the recommendations from survivors themselves.

Findings on Assault Characteristics

Survivors were asked several questions about the assault for which they sought services. Specifically, if they had ever experienced prior sexual violence, their age at the time of the assault, whether they knew the perpetrator and the gender of the perpetrator.

Nearly half of the respondents (49.2%) said they had been sexually assaulted before this time. Several studies have shown a relationship between child sexual abuse, adolescent sexual violence and later revictimization as an adult. The following text box shows the most current literature in this field. While understanding the current research on revictimization is important, it is also necessary to remember that no one asks for, causes, invites or deserves to be assaulted. Prevention of sexual violence lies with potential or past rapists, not potential or past victims.

Sexual Revictimization: Examining Risk Factors for Repeat Victimization

Sexual abuse early in life has been implicated in vulnerability to repeat sexual victimization. There is a growing literature on this relationship, the risk factors and psychological correlates, and interventions. In the 1980s a seminal study uncovered the correlation between childhood sexual abuse (CSA) and rape in adulthood (Russell, 1986). In a retrospective study of 152 women who had experienced intrafamilial sexual abuse (incest) before the age of 14, 63% also experienced rape or attempted rape after the age of 14.

Subsequent studies have found that women who experienced sexual assault in childhood were two to three times more likely to be raped or sexually assaulted after the age of 16 (Gidycz et al., 1993; Kilpatrick et al., 1997; Tjaden & Thoennes, 2000; Siegal & Williams, 2003). Recently, Classen and colleagues (2005) reviewed 90 empirical studies focused on the prevalence of and risk factors for sexual violence revictimization and confirmed the elevated risk of sexual assault among child sexual abuse survivors. Desai et al. (2002) found rates of sexual reassault were even higher for male survivors of childhood sexual abuse: they were 5.5 times more likely to be revictimized in adulthood.

Sexual abuse in childhood also increases the risk of sexual victimization in adolescence. A New Zealand study followed a birth cohort that represented 83% of the births in a 4.5-month period in 1977. When the cohort turned 18, the researchers inquired about their childhood and adolescent sexual experiences. Six percent reported rape in childhood, and 7.5% reported rape or attempted rape between the ages of 16 and 18 (Fergusson, 1997).

However, there have been inconsistent results across studies as to whether sexual victimization in childhood alone is a risk factor for revictimization in adulthood or whether childhood sexual abuse *and* adolescent sexual abuse increases the risk for sexual assault in adulthood and why this relationship occurs. For example, both studies in the National Institute of Justice's Research in Brief, *Violence Against Women: Identifying Risk Factors* (USDOL, 2004), despite describing very different populations—primarily white college students in one study and mostly black urban women in the other—found

that experiencing sexual abuse in childhood and adolescence significantly predicted revictimization in adulthood, but neither childhood nor adolescent sexual abuse alone significantly increased the risk of rape in adulthood.

Several studies have shown that more severe sexual abuse in childhood—including the use of force, penetration, closer relationship to the perpetrator and longer duration—increases the risk of revictimization (Fergusson, 1997; Kessler & Bieschke, 1999; Humphrey & White, 2000; Arata, 2000). The underlying reason may be that trauma has a cumulative impact on development and coping that increases the risk of revictimization (Jankowski et al., 2002; Moeller et al., 1993). One line of research has examined the mediators that underlie the relationship between sexual assault in childhood or adolescence and revictimization. For example, it has been found that alcohol abuse in itself increases the risk of sexual assault, and also that there is a high rate of alcohol abuse among survivors of CSA and adolescent sexual abuse. Similarly, CSA survivors often have multiple sexual partners and have sex with people they know less well, as a result of what Finkelhor and Browne (1985) term “traumatic sexualization,” and the number of sexual partners increases risk of sexual assault. Finally, a symptom of traumatic stress that children are particularly likely to develop is dissociation, or detachment from the self, during stress. Dissociation can decrease the ability both to recognize danger and to defend oneself from sexual assault.

A recent study tested three theoretical models for explaining revictimization among college women and found that self-blame, posttraumatic stress and number of sexual partners did not mediate repeated experiences of sexual victimization (Wasco, 2004). Other studies have focused on using an ecological framework to better understand the ‘why’ of sexual revictimization. This model looks at factors outside of the victim, including childhood factors, such as family environment, contextual factors including the behavior of the perpetrator, and societal and cultural factors that impact revictimization (Messman-Moore & Long, 2003).

Findings from National and Global Studies on Non-Stranger Sexual Violence

The National Violence Against Women Survey (NVAWS), conducted with a random sample, found that 15% of US women over the age of 17 reported having been raped (Tjaden & Thoennes, 2000).

Two-thirds of the rapes of victims over the age of 12 were committed by someone known to the victim. A friend or acquaintance of the victim committed nearly half the rapes; an intimate partner committed 17% and another relative 3% (Catalano, 2005). Men are more likely to be raped by strangers (29%) than women (17%) (Tjaden & Thoennes, 2006). Attackers of college women are even more likely to be known to the victim. The National College Women Sexual Victimization Survey found that 90% of the offenders were known to their victims (Fisher, Cullen & Turner, 2000).

For adult women, the highest risk of rape comes from an intimate partner. A Canadian study found that 30% of women who were raped in adulthood were assaulted by their intimate partners (Randall & Haskell, 1995). In the US, for 46% of women who have experienced rape or attempted rape the perpetrator was a spouse or ex-spouse, a current

or former cohabiting partner, a date or a boyfriend or girlfriend, with over half by a current or former spouse or cohabiting partner (Tjaden & Thoennes, 2000). Most of these intimate partner assaults of women (69%) occurred during the relationship; 25% occurred both during the relationship and after the relationship ended (Tjaden & Thoennes, 2000).

Rape of women by male intimate partners is a global problem. In a ten-country study of violence against women, the World Health Organization (WHO) found that rates of sexual violence perpetrated by male partners ranged from a low of 6% in Japan to a high of 59% in Ethiopia (WHO, 2005). The WHO study provides one of the first cross-country examinations of patterns of partner violence. In most of the countries in the study, from 30% to 56% of women who had experienced any violence by an intimate partner reported both physical and sexual violence (WHO, 2005). This pattern did not hold true for all sites, however: across Thailand and in provincial Bangladesh and Ethiopia, a large proportion of women experienced sexual violence only.

“Many people [interviewed me], none took me seriously; really a nightmare I will never forget, worse than the actual sexual molestation.”

—43-year-old female

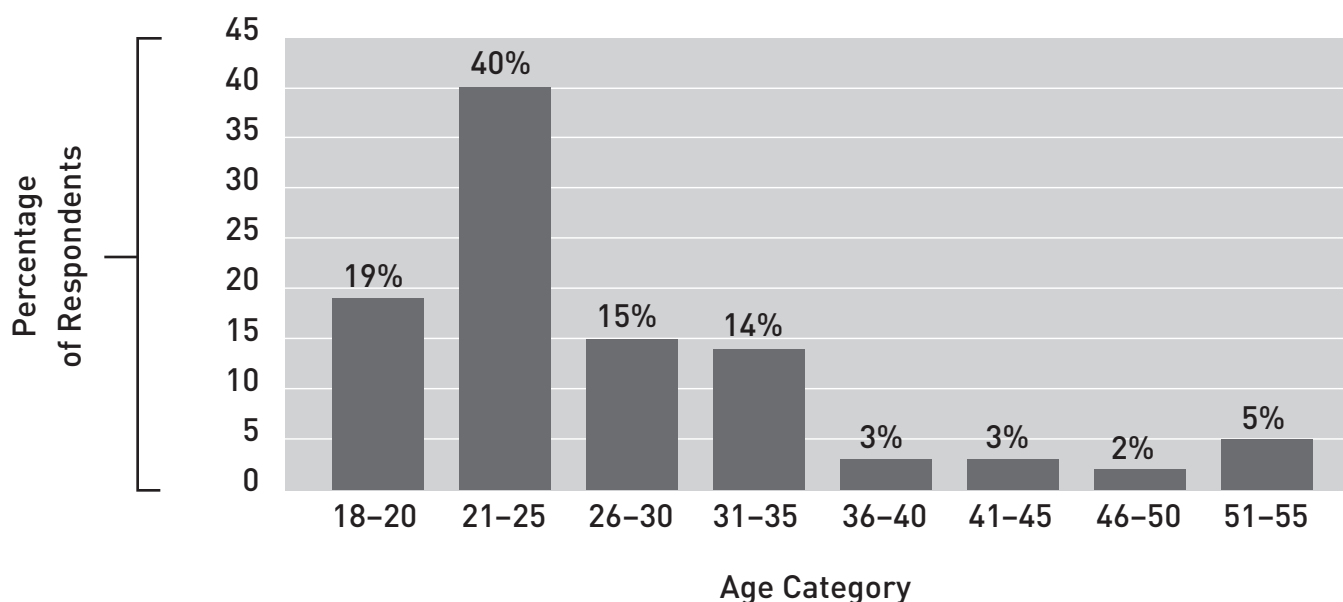
Chart 1 highlights the age at which the assault took place. For 40% of the respondents the assault took place when they were 21-25 years old. Overall, 59% of the sexual assaults took place between the ages of 18-25. Another 14% of respondents reported that the sexual assault took place when they were between the ages of 31-35 years old. Twenty-eight was the average age at the time of the assault (range was 18 to 54).

The majority (93.9%) of the perpetrators of sexual violence in this study were male. This is consistent

with other studies that show that sexual violence is most often perpetrated by men against all victims: men, women and children.

In this study, 60% of respondents knew their attacker and 40% reported the attacker was a stranger. For many respondents the person was a friend (31.7%), dating partner (19.5%), someone the respondent had seen before but was not friends with (17.1%), a person of authority (7.3%) such as a boss, teacher, commanding officer, etc., or someone they had met on a blind date or at a bar (7.3%).

chart 1: Age When Sexual Assault Occurred



Findings on Help-Seeking Behavior

Respondents who participated in this study, all of whom accessed services, were asked about their help-seeking behavior following the assault. Specifically, they were asked which service they contacted first, in which borough this service was located, how long after the assault did they seek help from this place, if this first point of contact referred them for further services, and the total number of services they sought after the assault.

This study only surveyed survivors who had accessed services after their assault. When asked which place they contacted first after the sexual assault, 27.7% responded that they called 911. Another 20% contacted security or the police, and 15.4% went to a hospital first. A smaller percentage contacted a counselor first at either a rape crisis/victim assistance program (12.3%) or through a private counselor (10.8%).

We can see from Chart 2 that survivors are more likely to seek services in the borough where the assault happened as evidenced by the case of Brooklyn. In Brooklyn, we see that more respondents in this study were assaulted outside of the borough in which they live and instead of seeking services in their borough of residence, they sought services in the borough in which they were assaulted. This is likely due to the fact that ambulances will transport victims to the nearest hospital facility, law enforcement will come from the nearest precinct and the case must be prosecuted in the borough in which

the assault took place. Rape crisis services, however, can be sought in any borough.

Of the sixty-two respondents who answered the question of when they sought help, the vast majority contacted the first service within a day of the assault occurring (56.5%) or within three days of the assault (19.4%). Although it is also common that survivors contact services much later, only 6.5% or 4 respondents, sought help more than one year after the assault.

chart 2: Borough of Residence, Assault and First Service Contacted

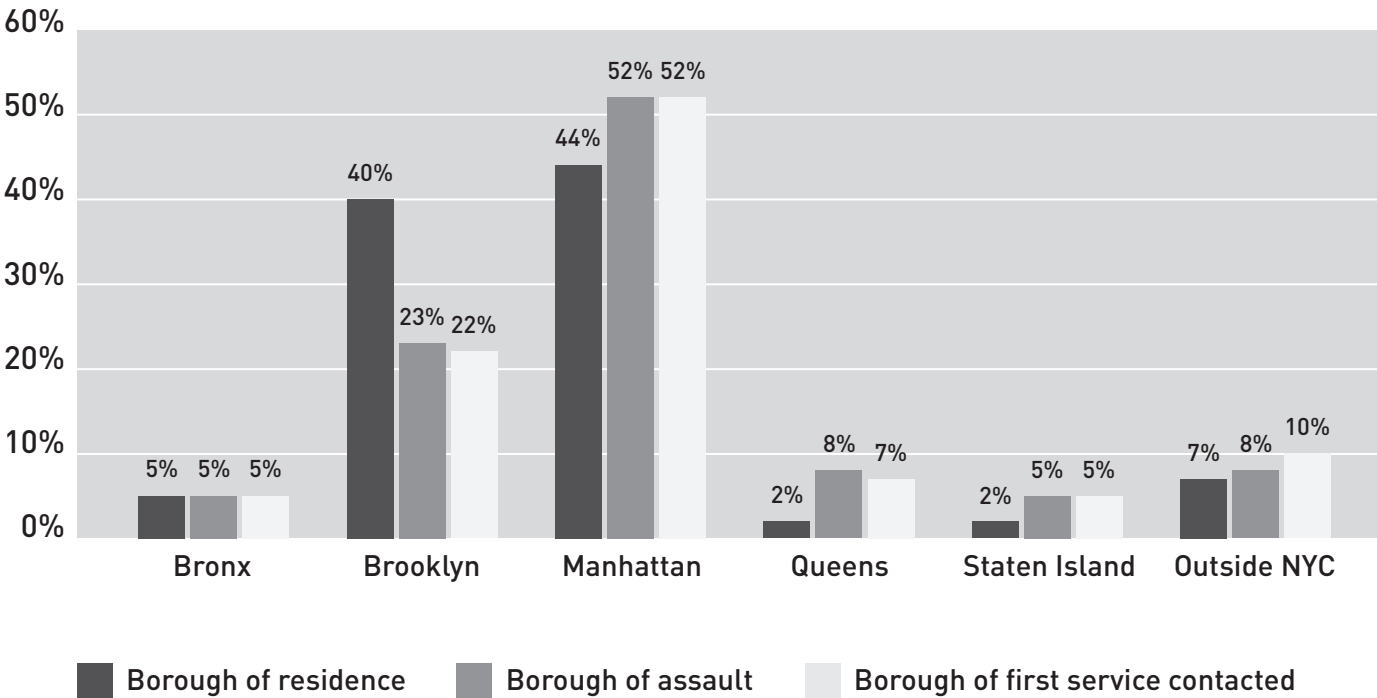


Chart 3 shows that for nearly half of the respondents (41.9%) the first service contacted did *not* advise them to go for further services. Despite this low referral percentage, 61% of respondents contacted three or more services after the sexual assault.

Chart 4 shows all the services that were contacted after the assault; a large number of respondents (67.7%) contacted rape crisis/victim assistance programs often in conjunction with other services. It should be noted that recruitment for survey respondents took place in rape crisis programs and on the web (see Appendix A for more details). A little over half of the respondents contacted security/police and just under half went to the hospital after the assault. Much smaller percentages called a hotline (15.4%) or went to a church or faith-based organization after the assault (10.8%). Other services contacted include primary health clinicians, gynecologists and a public advocate.

Survivors told the details of their sexual assault to a median of four people (average seven people with a range from 1-60) including doctors, nurses, police officers, counselors, etc.

chart 3: Respondents (%) Referred to Other Services from First Point of Contact

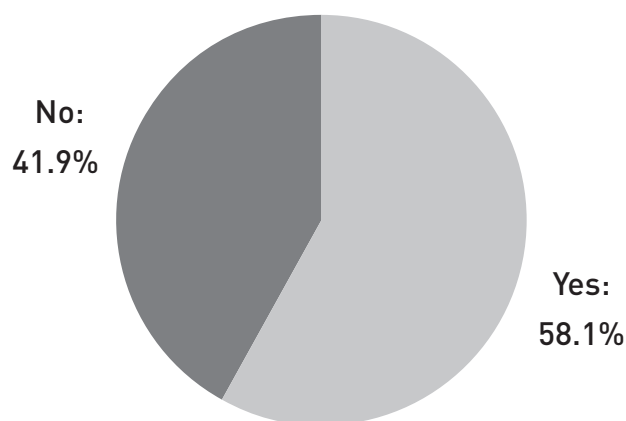
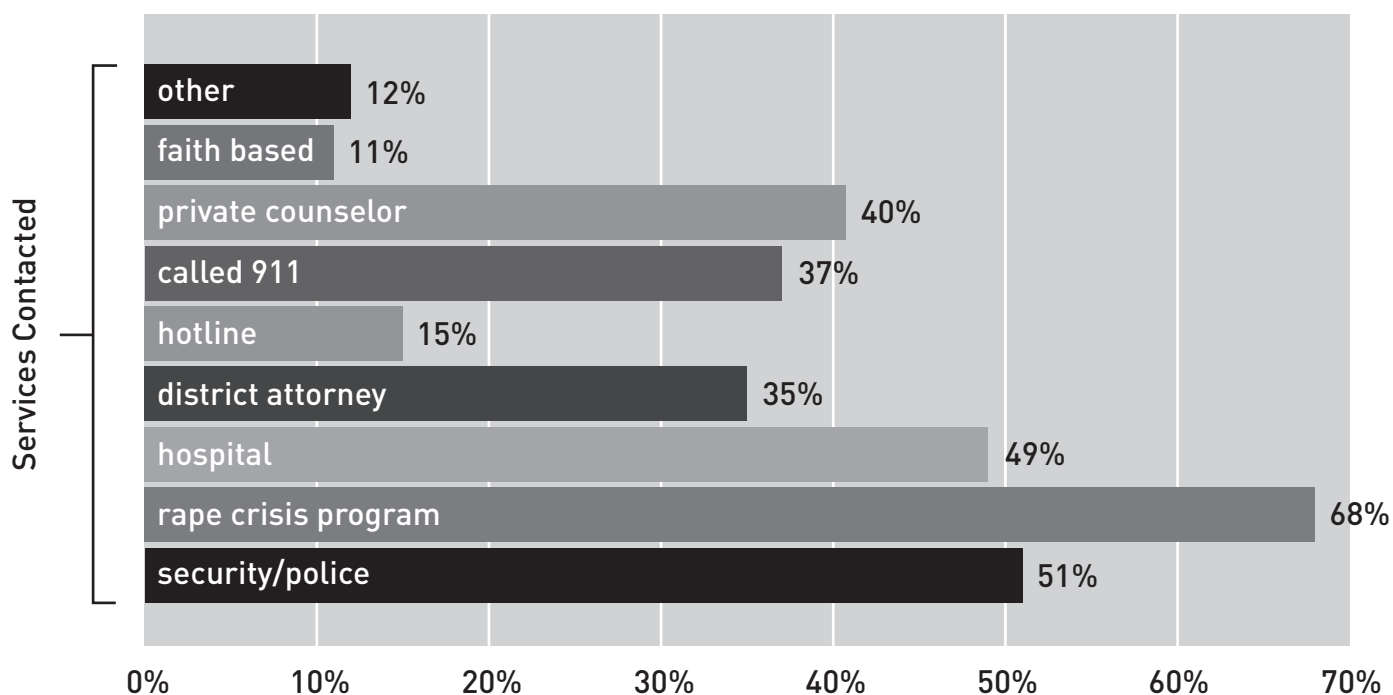


chart 4: All Services Contacted After Assault



“The environment [hospital] was not at all comforting. Again, I would suggest that they have trained, sensitive advocates readily available.”

—21-year-old female

Chapter 2: Hospital Services

Many survivors choose to go to a hospital after a sexual assault to receive care for injuries, as well as for preventive treatment for sexually transmitted infections including HIV and emergency contraception. Once they present at the hospital, patients are also offered psycho-social support for acute trauma, and the option of forensic evidence collection.

This study assessed the following concerns about hospital services: **1)** what prevents survivors from going to the hospital; **2)** experiences with clinicians; **3)** satisfaction with services, **4)** the positive and negative aspects of going to the hospital and **5)** recommendations for improving hospital services for sexual assault survivors. This chapter also includes information on an underserved population identified in the study: survivors with mental illness.

Hospital Care for Sexual Assault Survivors in NYC

Every hospital in New York State must ensure that all victims of rape or sexual assault who present at the hospital are provided with care that is comprehensive and consistent with current standards of practice. By Public Health Law entitled Treatment of Sexual Offense Victims and Maintenance of Evidence in a Sexual Offense (2002), every hospital in New York State must provide treatment to victims of a sexual offense and be responsible for:

1. Maintaining sexual offense evidence and chain of custody, and
2. ‘contacting a rape crisis program or victim assistance organization, if any, providing victim assistance to the geographic area served by the hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services.’

By law, the patient must be told about the local rape crisis services and that a rape crisis advocate can accompany him/her during the exam if s/he wishes.

In 2000, Governor Pataki signed into law the Sexual Assault Reform Act (SARA) which mandated that SAFE programs be available throughout the state. The NYS Department of Health promulgated standards under SARA for SAFE Centers of Excellence. SAFE programs and clinicians aim to ensure that sexual assault survivors are provided with competent, compassionate, victim-centered and prompt care, while at the same time ensuring forensic evidence collection and preservation. SAFE program philosophy is based upon the belief that providing a specialized standard of medical care, advocacy and evidence collection to victims of sexual assault will support recovery and prevent further injury or illness arising from victimization, and may increase the successful prosecution of sex offenders for victims who choose to report the crime to law enforcement (NYS DOH, 2004.).

All hospitals, regardless of whether they are a SAFE program, are required to provide medical care to patients reporting a sexual assault. In 2003, a new law required hospitals that treat sexual assault patients to provide information on emergency contraception. The Department of Health was charged with developing and producing informational materials on emergency contraception to be used by all hospitals in New York State. These materials are currently available in eight languages. If requested by the victim, the hospital must directly provide emergency contraception.

In New York State, the Department of Health (DOH) publishes a *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* (2004) that details the standard for treatment of survivors in emergency departments throughout the state. To become a Sexual Assault Forensic Examiner, a doctor, nurse, nurse practitioner or physician assistant must attend a NYS DOH-certified training program, such as the training program offered through the NYC Alliance Against Sexual Assault, for a five-day comprehensive course on medical and forensic treatment. These clinicians must then complete

a preceptorship or 'mentoring' with a certified examiner to complete the process. If a doctor, nurse, nurse practitioner or physicians assistant received training in another state or through the International Association of Forensic Nurses (IAFN), their training would be reviewed by a DOH-certified training program, and they would be able to apply to DOH to become a certified SAFE clinician.

To become a specialized SAFE Center of Excellence, a hospital or other center must meet the following criteria that are above and beyond what is required by state law:

1. Maintain a designated and appropriately equipped private room in or near the hospital's emergency department to meet the specialized needs of sexual assault patients. Accommodations must include access to a shower and be handicap accessible.
2. Maintain a supply and provide an initial supply to patients, as medically indicated, of prophylaxis for HIV.
3. Establish an organized program/service specifically to carry out and oversee the provision of sexual assault services. This would include the development and implementation of policies and procedures detailing staffing requirements, initiating and conducting community outreach programs, participating in an organized data collection system, and routinely following-up with patients/law enforcement officials and crime laboratory personnel regarding the credibility of evidence collection activities.
4. Designate a program coordinator to exercise administrative and clinical oversight for the program.
5. Ensure that the program includes a cohort of specially trained Sexual Assault Forensic Examiners (SAFEs) who have been prepared through an intensive classroom and preceptor training program and have been certified by NYSDOH to conduct sexual assault exams.

6. Establish/participate in an interdisciplinary taskforce that includes local rape crisis centers and other service agencies, and law enforcement representatives/local prosecutors to develop services that meet community needs and to ensure that quality victim services are available.
7. Maintain Sexual Assault Forensic Examiners on-site or on-call available to the patient within 60 minutes of arriving at the hospital, except under exigent circumstances.
8. Routinely use the New York State Evidence Collection Kit, if the patient consents to having evidence collected.
9. Coordinate outreach activities in the community and with other hospitals to share best practices, provide training opportunities and promote the availability of programs, to the extent feasible.
10. Participate in regional and statewide quality assurance initiatives designed to measure program effectiveness and meet reporting requirements (NYS DOH, 2004).

As of May 2006, 15 hospitals representing 17 emergency departments have earned the NYS DOH designation SAFE Centers of Excellence in NYC (NYS DOH, 2006). This number represents 27% of the emergency departments in the city. Many hospitals may have some SAFE services available to survivors but may not have met all of the criteria to be designated as a SAFE Center of Excellence or may be in the process of accreditation (For a more detailed examination of what services are offered in NYC's Emergency Departments, consult the Alliance's companion report entitled *How SAFE is NYC? Sexual Assault Services in Emergency Departments*). In addition, Mayor Bloomberg mandated the creation of Sexual Assault Response Teams (SART) at the Health and Hospital Corporation (HHC) facilities (the public hospitals). Currently there are SART programs in the Bronx, Brooklyn, Manhattan and Queens. The HHC SARTs operate similarly to SAFE Centers, except that the medical provider and advocate can travel to any of the HHC hospitals within a specific borough to provide care.

Measuring satisfaction with hospital services

Measuring satisfaction with acute care services is a developed field in patient satisfaction research. Satisfaction surveys are common procedure for quality assurance in most hospitals throughout the city. The constructs for measuring satisfaction are clear—the patient enters with a complaint and the clinicians work to ensure the well-being of the patient. Clear guidelines are laid out in the *New York State Protocol for the Acute Care of the Adult Patient Reporting a Sexual Assault* about what procedures should be followed, what should be provided to the patient, and how the patient should be informed throughout the whole process.

Research Questions and Findings

What prevents survivors from going to the hospital?

In this study, over half (56.1%, n=26) of survivors went to the hospital after the sexual assault. For those that did not go to the hospital, we asked “Was there anything that prevented you from going to the hospital?” Twenty-one respondents identified five major themes for not going to the hospital after the sexual assault:

- **Too traumatized and fearing for safety and well-being**

“All I can remember is laying on the floor balled up in a knot, extremely traumatized, very terrified, cold, shaking, I felt wet, dirty, disgusted, shamed...not able to move...balled myself up in the fetal position, thought I was dying.”
—41-year-old female

“I was just trying to protect my children and myself first. I did not think of it right away.”
—31-year-old female

“I was afraid and did not know what to do.”
—27-year-old female

“The person was a work supervisor threatening the livelihoods of others, is violent and has a history of retaliating against people.”
—respondent, age unknown

- **Thought it was their fault/embarrassed to seek care**

“I felt that I brought it on myself, who would believe what had happened, it would have been consensual at first but then things just went all wrong.” —21-year-old female

“Went to the doctor 2 to 3 months after the incident. Did not want to be embarrassed in front of others. I didn’t have any evidence, I felt I washed it away. I felt very dirty, then, the time of the month came 2 days later. I felt who would want to examine me like this. I had finally got coverage but had a pediatric Dr., got this straightened out then didn’t know what Dr. that accepted my coverage would see me. It was the worst time of my life. Not having a Dr. when most needed.”
—35-year-old female

“I don’t have health insurance and I was drunk when the incident occurred and I thought it was my fault.” —37-year-old female

- **There were no physical injuries**

“What happened to me did not require medical attention.” —32-year-old female

- **Sexual assault did not include intercourse**

“My sexual assault didn’t involve intercourse, but oral sex. I didn’t feel like I had to go to the hospital afterwards.” —34-year-old female

“There wasn’t full penetration.”
—25-year-old female

At the hospital, what services do survivors find helpful?

Victim Advocates

Victim advocates provide emotional support to a victim of sexual assault in the hospital setting. In New York City, victim advocates are usually either community volunteers who complete a 40-hour training administered by their local rape crisis program and overseen by the NYS DOH, or they are hospital social workers. There is at least one hospital in NYC that trains ancillary emergency room staff (patient care technicians) to serve as patient advocates.

The 2004 *National Protocol for Sexual Assault Medical Forensic Examinations* outlines the role of patient advocates. Advocates may accompany victims from the initial contact and the actual exam through to discharge and follow-up. In particular, they:

- Assist in coordination of victim transportation to and from the exam site;
- Provide victims with crisis intervention and support to help cope with the trauma of the assault and begin the healing process;
- Actively listen to victims to assist in sorting through and identifying their feelings;
- Let victims know that their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocate that victims' self-articulated needs be recognized and their choices be respected;
- Advocate for appropriate and coordinated response by all involved professionals;
- Support victims in voicing their concerns to other service providers;
- Respond in a sensitive and appropriate manner to victims from different backgrounds and circumstances, and reduce barriers to communication;
- Serve as an information resource for victims (e.g. answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of medical and evidence collection procedures, explain legal aspects of the exam, help them understand STIs, HIV and pregnancy treatment options, and provide referrals);
- Provide replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aid victims in identifying individuals who could support them to heal (e.g. family members, friends, counselors, religious or spiritual counselors/advisors, and/or teachers);
- Help victims' families and friends cope with their reactions to the assault, providing information and increasing their understanding

of the type of support victims may need from them; and

- Assist victims in planning for their safety and well-being (USDOD, 2004).

Volunteer victim advocates are a crucial component of the care of survivors in the hospital. In this study, survivors were asked if a volunteer victim advocate assisted them in the hospital setting. The question was worded as follows: "Sometimes survivors have a counselor who helps guide them through the visit at the hospital. This counselor is called a victim advocate (also known as a rape crisis advocate or rape crisis counselor) and is not part of the hospital staff. Did you have a victim advocate at the hospital?" 50% (n=13) of those who went to the hospital said they had a victim advocate at the hospital. For those respondents, the majority were very satisfied (50%) or satisfied (28.6%) with the victim advocates.

On the importance of rape crisis advocates, one survivor noted:

"Hospitals need to acknowledge that people who were raped before rape advocates evolved, were considered the instigators and this is something we will always live with...even though we know now, it isn't true, it affected our relationships with family and friends and how we've developed socially..." 50-year-old female

Chart 5 shows many of the services offered by volunteer victim advocates to survivors in the hospital setting. Nearly all of the survivors who had victim advocates stated that they received:

- information about counseling (93%),
- the support they needed during the hospital visit (79%),
- information about reporting to the police (71%) and
- an explanation of the components of the medical exam from the victim advocate (79%).

Overall, the impact of victim advocates is a very positive one. In fact, the presence of a victim advocate had a statistically significant impact on the

survivor's satisfaction with the care they received at the hospital ($p < .05$). Survivors who had the help of a victim advocate report being 'very satisfied' or 'satisfied' more than survivors who did not have the help of the victim advocate.

How do survivors feel about their experiences with clinicians?

Exactly half of the respondents said they waited a long time to see a clinician (Doctor, Nurse, Physician Assistance, Nurse Practitioner) when they went to the hospital after the sexual assault. One respondent said:

"No one bothered to speak to me. I was there with my 12 year old sister and her 14 year old friend. Not ONE person spoke to us. We had to wait for

family to get there. I was also an employee of one of the doctors there. There was ZERO counseling. We were put in a room and couldn't even get a nurse to stay with us." 32-year-old female

Among those seeking care at a hospital ($n=32$), one-third reported that the clinician made a follow-up medical appointment (38%) and slightly fewer were asked by a clinician if they had a safe place to go after leaving the hospital (34%) or were given information about reporting to the police (34%). More respondents were given information about emergency contraception when appropriate (68%), were given information about sexually transmitted infections (STI's) including HIV (59%) and a little over half were given information about medicine to help prevent the HIV infection (post exposure prophylaxis).

chart 5: Victim Advocate Services

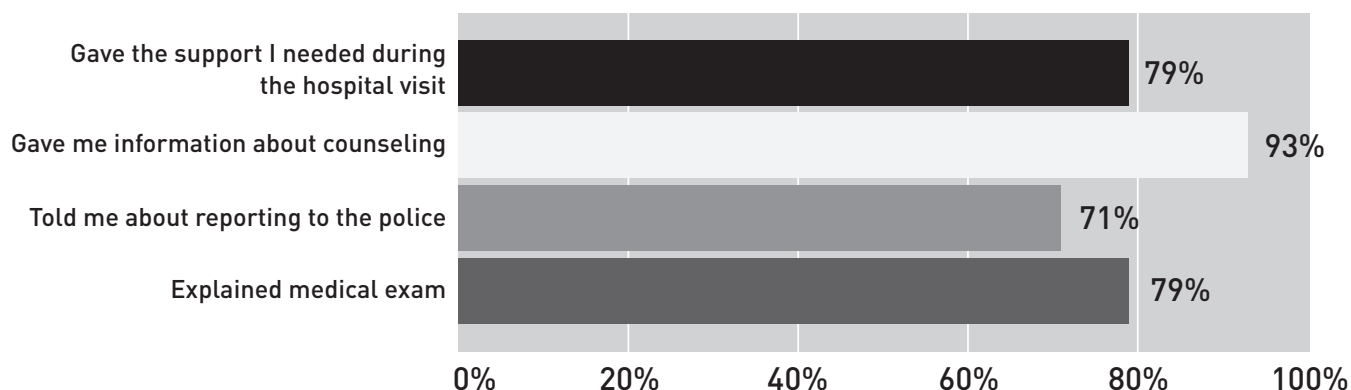
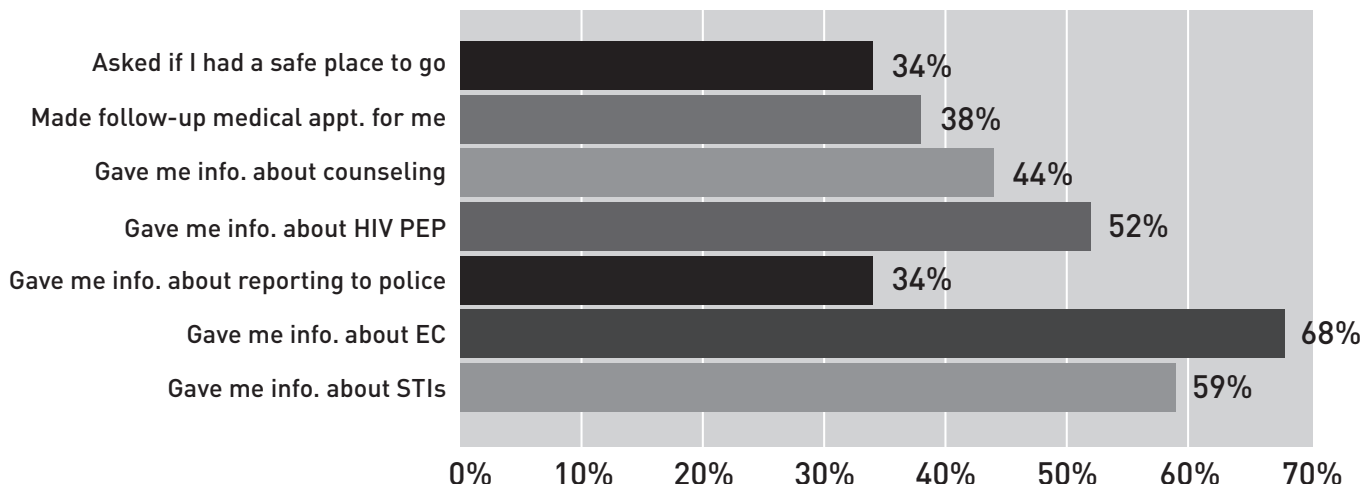


chart 6: Treatment by Doctor/Nurse



Survivor Voices:

What was the best thing about going to the hospital?

"Feeling more secure after getting the tests/medication I needed."

—21-year-old female

"The victim advocate who arrived while I was there and receiving medication to prevent any disease."

—33-year-old female

"I felt in control again, I felt like I was doing everything I could."

—34-year-old female

"Immediate rape kit and drug test were performed. Female officer supportive and with me [the] whole time. Special Victim's Unit agent came. Rape advocate supportive and necessary. Phone calls to family."

—24-year-old female

"I was checked for diseases, also somebody listened, but only about 'that rape'"

—50-year-old female

"I knew that I was doing everything to prevent/treat STDs and HIV."

—23-year-old female

"The staff realized the importance of listening and working with the patient for their well-being, and refused to disclose my personal information to my mother..."

—36-year-old female

"I was taken by the paramedics that the police patrol that came to apartment called."

—30-year-old (gender not given)

"It eased my worries about STDs and HIV."

—28-year-old female

"My injuries were noted and attended to. In addition, my medical examination provided the essential evidence."

—57-year-old female

"Learning I was okay physically."

—25-year-old (gender not given)

"Precautionary measures were taken against STDs and pregnancy."

—26-year-old female

"The validation."

—26-year-old female

"The victim's advocate and a small sense of empowerment."

—25-year-old female

"They gave me STD shots and believed me."

—54-year-old male

"I was able to do rape evidence kit with enough evidence to have a more definite conviction."

—32-year-old female

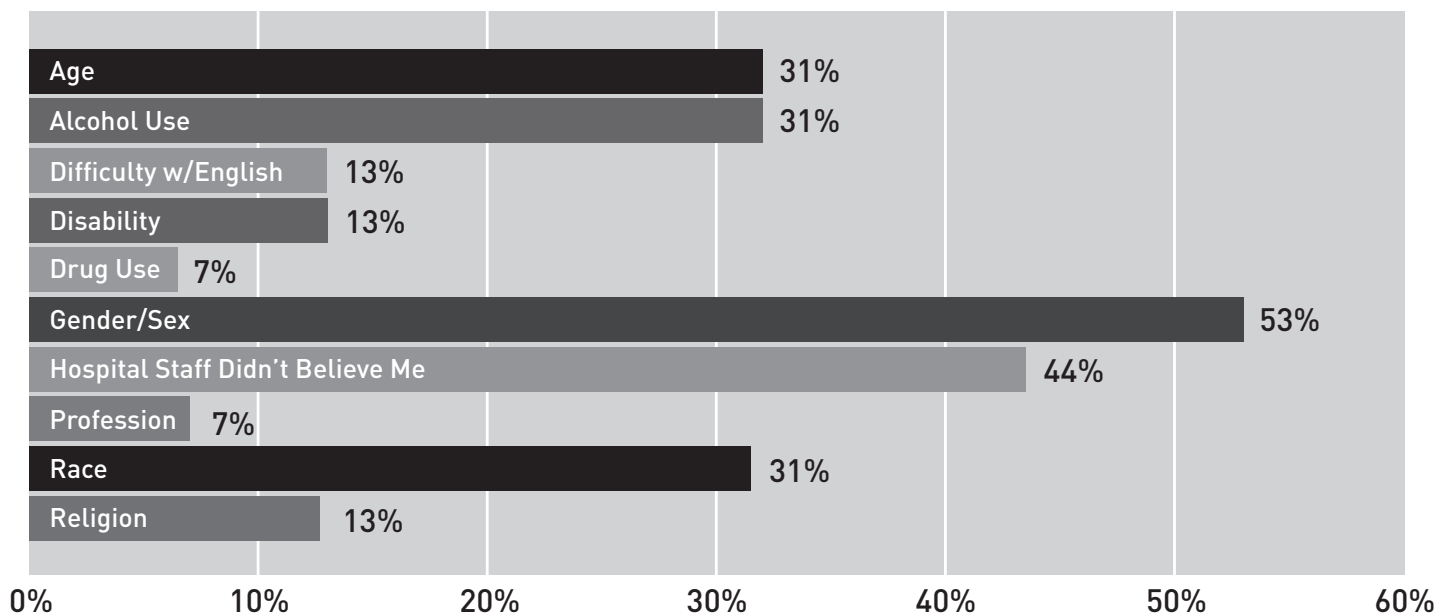
"Counseling, feeling safe."

—44-year-old female

Of respondents who went to the hospital after the assault, 60% went within the last three years. Among the survivors visiting the hospital in the past three years, a higher percentage were asked if they had a safe place to go to after leaving the hospital (44%), more follow-up medical appointments were made (40%), more information was given about HIV PEP (61.5%), more information was given about EC (67%) and STIs (67%) where appropriate. For more recent hospital visits, fewer respondents were given information about other services such as reporting to the police (33%) and counseling (38.8%).

Half of the survivors surveyed reported feeling treated poorly at the hospital (n=16). Chart 7 shows the main reasons why respondents felt clinicians treated them poorly. Overwhelmingly, of those that felt poorly treated, respondents felt that their gender biased clinicians against them. Importantly 44 percent of these respondents felt like hospital staff did not believe their disclosure of sexual assault. Unfortunately data limitations prevent further exploration of these reasons, showing a clear area for additional research.

chart 7: Why Respondent Felt Poorly Treated at the Hospital



The respondents were asked to provide any other reasons they felt they were treated poorly at the hospital:

"I was behaving badly; I was somewhat hostile and often tearful." —37-year-old female

"The doctor suggested I should date and forgive my boss for raping me because he was wealthy and 'gentle.' This made me feel embarrassed about being angry for being physically forced to have unwanted intercourse with him." —23-year-old female

"They were not experienced with date rape victims and [there was] very little communication between the internist, attending and ob/gyn."

—26-year-old female

"was brought to the PEDIATRICS ER—TOTALLY OUT OF LINE!!!"

—32-year-old female (emphasis original)

Providing Care to Survivors with Mental Illness

"Once we have labeled a woman as suffering from a major mental illness, whether that label is an accurate assessment or not, we view her reports of sexual and physical abuse through the colored lens of her diagnosis...The stigma of her diagnosis is often sufficient to call her account into question." (Harris & Landis, 1997)

Sexual violence in the lives of both men and women with mental illnesses is widespread. A two-state study found that 26% of men and 64% of women with severe mental illness had been sexually assaulted at some point in their lives (Mueser et al., 1998). In a recent study, 782 men and women with severe mental illness were interviewed. In this study, 20.3% of the women and 7.6% of the men reported a sexual assault within the past year and 57.1% of the women and 24.5% of the men experienced a sexual assault during adulthood (Goodman et al., 2001).

Emerging research focuses on adult survivors of sexual violence who have a mental illness and their treatment by service providers. A recent study conducted in New Zealand found that when sexual abuse was disclosed to service providers at a community mental health center that these staff noted the abuse in their clients files but did very little if nothing to address the violence. Only 33% of the treatment plans mentioned the abuse and only 22% of the abused clients received abuse-focused therapy. None of the assaults were reported to the police (Agar & Read, 2002).

A chilling and thoughtful article written by the mother of a daughter who was sexually abused as a child and suffered from chronic mental illness tells of the retraumatization of her daughter in the mental health system. The account underscores how early childhood trauma experiences are mimicked

in common mental health institutional practice (Jennings, 1994). Other research has also reflected on the practices of working with mental health patients such as using coercion, constraints and involuntary treatment that may cause retraumatization to survivors of sexual violence (Clark et al., 2005).

All service providers need to be cognizant of the stigmatization that is associated with mental illness and provide victim-centered care that does not blame the victim. One survivor in the current study spoke of her experiences in the hospital setting:

"The doctor walked in the ER just looked at the notes and looked at the meds I take- I have a mental illness and he looks at me and ask me how do I know I was raped? And from there on it felt like it was going to happen again so my agenda switched and it was just to get out of there as quickly as possible."

When asked what the worst thing was about going to the hospital, she responded:

"That I went to seek treatment- I was scared anyway...I called my mentor and I told her. She demanded me to go to the hospital and to make sure I did she had spoke to my mom and had my mom take me- but the experience there reinforced my fears-and now simple things that I would have went for I can't anymore."

Recommendations for changing the hospital system:

"That people who are survivors of sexual assault wouldn't be 'punished', as I have, by going to a mental hospital after their attack(s)."

Survivor Voices:

What was the worst thing about going to the hospital?

"I felt like I wasn't believed, I wasn't informed about what was necessary medically vs. legally." —23-year-old female

"Having to expose myself in an uncomfortable way again so soon after the attack. Having to answer questions...the mental energy it took to think logically at that point."

—28-year-old female

"The confusion. First, I saw the internist who was going to perform the kit. However, she did not know what to do. When she came back in she told me that in order to perform the kit, the police would have to be involved. An hour later the social worker showed up and clarified the situation because I did not want police involvement. Then the attending came in and told me he could not answer my questions, but that the ob/gyn would be in to perform the kit. Several hours later the ob/gyn came in with a female doctor and another doctor who observed. They were kind and respectful, but without the attending ob/gyn, they would have not known what to do. I walked in at 8pm and walked out of the hospital at 4am the following morning. The hospital was very quiet that night."

—26-year-old female

"The doctor and nurse in the emergency room, in my opinion, weren't emotionally supportive of me." —41-year-old female

"The expense, the time wasted, the further insult to my body, my spirit, my mind, and the emotional aftermath of being treated so cruelly by everyone I came into contact with. Many of the people working at the hospital would not look me in the eye and they would not answer my questions. And when I cried, it terrified them. They did not know what to do with a person who had tears flowing down her cheeks. They panicked and looked

for ways to isolate me and deprive me of my freedom (such as being able to leave the hospital)." —37-year-old female

"I was very weary and needed to clearly recount details many times."

—57-year-old female

"The long waits, the educational video about HIV playing over and over in the lobby as I waited to be tested for HIV, the lack of comfort or understanding of the doctors and counselors, feeling like I was a number, being made to feel guilty for my sexual choices and for the assault by the counselors." —21-year-old female

"Having to explain everything so many times."

—25-year-old (gender not stated)

"They charged me a lot of money after promising I wouldn't have to pay for the visit. They couldn't figure out how to work the camera to take photographs so I was stuck sitting naked on the exam table for an hour. They were training someone on how to do the exam. It didn't seem like anyone knew what they were doing." —26-year-old female

"It is embarrassing and a little scary, I just wanted to start forgetting."

—34-year-old female

"Was not offered emergency contraception, did not offer info about HIV prevention, did not talk to me much, was not sensitive to my situation, made follow-up appt. too far from treatment. Told me morning after pill would not be offered to me by them. Told me they wouldn't give me HIV prevention cocktail, to follow-up with primary care health provider if I was interested." —24-year-old female

Survivors' Recommendations

Twenty-four survivors gave their recommendations to help make hospital services better for other survivors.

1. Provide rape crisis advocates

Many respondents mentioned that the best way to improve services at the hospital is to provide trained rape crisis advocates.

"Have counselors and advocates readily available (let people know that the services are available so they don't have to ask) that are trained to be sensitive and not to blame the survivor, to be with the person throughout the whole process if they are asked to be. The examinations felt very violating...one doctor was talking to a nurse freely while he gave me a pap smear and didn't tell me what he was going to do and did it all very fast. The environment was not at all comforting. Again, I would suggest that they have trained, sensitive advocates readily available."

—21-year-old female

"Counseling follow-up."

—30-year-old (gender not stated)

"Have rape counselors available 24/7...There must be some sort of counseling for victims as well as a comfortable place to sit or lay down, not a cold dismal examining room." —32-year-old female

2. Provide comprehensive treatment

Several survivors mentioned that comprehensive treatment should be provided, and that when a hospital is unable to provide this treatment, a referral should be made to a hospital that can provide appropriate treatment.

"Emergency contraception should be offered and available on site. Pictures should be taken. HIV prevention cocktail should be available, explained and prescribed. Follow-up appt. should be made within 72 hours. If none of the above mentioned is possible, immediate referrals/transfers to other facility should be arranged."

—24-year-old female

"...A GHP [sic] and Rhophynol [sic] test should have been performed. I had to call the nurse the following day to see if I was tested. It was not the attending's choice to decide if that should have been performed..." —26-year-old female

3. Screening for sexual violence should occur in the ER

Several respondents stated that in order to make services better, it is important for the hospital to screen patients for sexual violence, both verbally and through their intake forms.

"When a girl comes in with broken ribs and says the injury happened while she was on a blind date, and then she starts sobbing, you might take her aside and ask her if she was sexually assaulted. I went to three different hospitals and not one person asked me that..."

—37-year-old female

"They should have a section especially for victims of violence and sexual abuse on their intake forms, and hire skilled doctors and counselors in this area." —36-year-old female

4. Better training for clinicians that handle sexual assaults

Many respondents mentioned that the attitudes of the clinicians needed to change in order to make the hospital a better place. Specifically, survivors mentioned making sure the victim feels believed, working with clinicians to make sure they are comfortable with handling sexual assault cases and providing training for interacting with survivors. All of these respondents were seen at a hospital that was *not* a NYS Department of Health certified SAFE Center of Excellence.

"I would have female doctors available to do the physical exams, and I would be sure the staff made the victim feel believed." —25-year-old (gender not stated)

"More comfortable attending doctors and more privacy." —33-year-old female

"Nurses and doctors should be more careful and sensitive to the patient's needs, including how they talk to the patient (tone of voice)..." —24-year-old female

"The doctor should be more patient and explain what she's doing and not make it seem like I am stupid for reporting a rape when there wasn't excessive physical damage." —23-year-old female

"Someone, somewhere needs to make sure that women who say they were crime victims on city/state/federal jobs get real help and investigations and care." —43-year-old female

5. Decrease the wait time in the ER

It was mentioned that one thing that could be improved for other survivors is to decrease the overall wait time experienced by victims in the ER.

"Decrease the wait time. My whole visit took 4 and a half hours. Which was torture...not being able to bathe, lying around half naked for hours alone just waiting and thinking." —28-year-old female

6. Have more specially trained clinicians

It was also mentioned that having more doctors and nurses to work exclusively with sexual assault victims would be an improvement at the hospital.

"The nurse and doctor were very busy and seemed very overworked. The nurse was somewhat short with me and the doctor had to keep going back and forth between patients. I would hire more doctors or nurses to handle these cases." —25-year-old female

***“I felt heard and understood when I really
needed help.” —34-year-old female***

Chapter 3: Rape Crisis Programs

Many survivors seek services from rape crisis or victim assistance programs to receive emotional support and begin the healing process from the trauma of sexual violence. Survivors seek care from these programs shortly after the assault or even many years later. Most programs in NYC offer short-term individual and group therapy at no cost to the survivor.

This chapter covers the services provided by rape crisis and victim assistance programs in NYC. This study measured the following aspects of rape crisis programs: **1)** what prevents survivors from going to a rape crisis program, **2)** experiences with rape crisis counselors, **3)** satisfaction with services, **4)** the positive and negative aspects of going to a rape crisis program and **5)** recommendations for improving rape crisis services for sexual assault survivors. This chapter also includes information on lesbian, gay, bisexual and transgender (LGBT) survivors.

Rape Crisis/Victim Assistance Programs in NYC

Rape crisis programs are the longest-standing community-based interventions for sexual assault. Rape crisis programs began in the 1970s, when volunteer activists received training on the crisis response and were on-call to come to the side of a rape victim wherever she was, and to accompany her to the hospital or police, or neither. As there were few women police officers when this movement was born, the police sometimes contacted the advocates to come and talk to and comfort a rape victim. Now, there are more than 1200 rape crisis programs in the United States (Campbell & Martin, 2001; Martin, 2005 as cited in Campbell, 2006) and over 20 rape crisis programs in New York City.

Rape crisis programs are now mainly located in hospitals, with a small number located in community-based or university institutions. Most programs have paid staff that can provide short-term, confidential, individual and group counseling to survivors, regardless of how long ago the assault

took place or where it occurred. Most of these programs also offer their counseling services for free. Increasingly, many programs are offering specialized services for adolescents, males, LGBT and non-English speaking survivors.

Volunteers are still an integral component of rape crisis programs and serve as rape crisis advocates to provide support to patients who go to the emergency department after an assault. These volunteers are carefully selected and receive 40 hours of training on crisis intervention, quality care, working with co-survivors and the hospital, law enforcement and criminal justice systems of NYC, and are often on-call once or twice a month.

A recent evaluation study that interviewed victims and reviewed records found that survivors who had the assistance of an advocate were more likely to have police reports taken and were less likely to be treated negatively by police officers (Campbell, 2006). Survivors who worked with an advocate during their emergency department care received more medical services, including emergency contraception and sexually transmitted disease prophylaxis, and reported significantly fewer negative interpersonal interactions with medical personnel than survivors who did not have an advocate (Campbell, 2006). Furthermore, survivors reported less distress from their emergency department visit when they had an advocate present (Campbell, 2006). While this initial research is important, it is also crucial to examine the impact of both counseling services and the rape victim advocate on the long-term health outcomes of survivors.

Measuring satisfaction with counseling services

Measuring satisfaction with counseling services is also common procedure for quality assurance and program improvement in many counseling centers throughout the city. All of the rape crisis programs operate under clear guidelines regarding patient care, privacy and confidentiality. The more

difficult construct is measuring satisfaction *across* programs, as each program is different and may have a different counseling approach. In this study, the satisfaction measurement is subjective; we asked survivors if they felt better as a result of their counseling experience. We did not ask survivors to reflect on the method of counseling; rather we asked them how the counseling and the approach made them feel.

Research Questions and Findings

What prevents survivors from going to a rape crisis program?

In this study, 70.6% (n=36) of survivors went to a rape crisis or victim assistance program after the sexual assault. More respondents reported contacting a rape crisis program (n=44) than those who reported going to a program (n=36). More survivors went to a rape crisis program than any other service. For those that did not go to a rape crisis program, we asked “Was there anything that prevented you from going to a rape crisis or victim assistance program?” Fourteen respondents identified the main reasons for not going to a rape crisis program after the sexual assault:

- **Accessibility**

Several survivors mentioned that accessibility was a major reason they did not go to a rape crisis program.

“Lack of wheelchair accessibility.”
—55-year-old female

“I am looking for a counselor, which seems to be difficult to find.” —26-year-old female

- **Prior negative experience with service providers**

Several respondents mentioned that prior bad experiences with service providers, such as the police or hospital staff, led them to not want to go to a rape crisis program.

“All I can remember is that I was so disgusted and humiliated after the way I was treated by NYPD I did not have the will or the strength to go on any further.” —41-year-old female

- **Fear**

A few respondents mentioned that fear played a role in not seeking help from a rape crisis program.

“Afraid to even leave the house.”
—25-year-old female

“For more than 10 years threats [from perpetrator] including jail threats and thugs hired to threaten me.” —49-year-old, gender not stated

- **Seeking counseling services elsewhere**

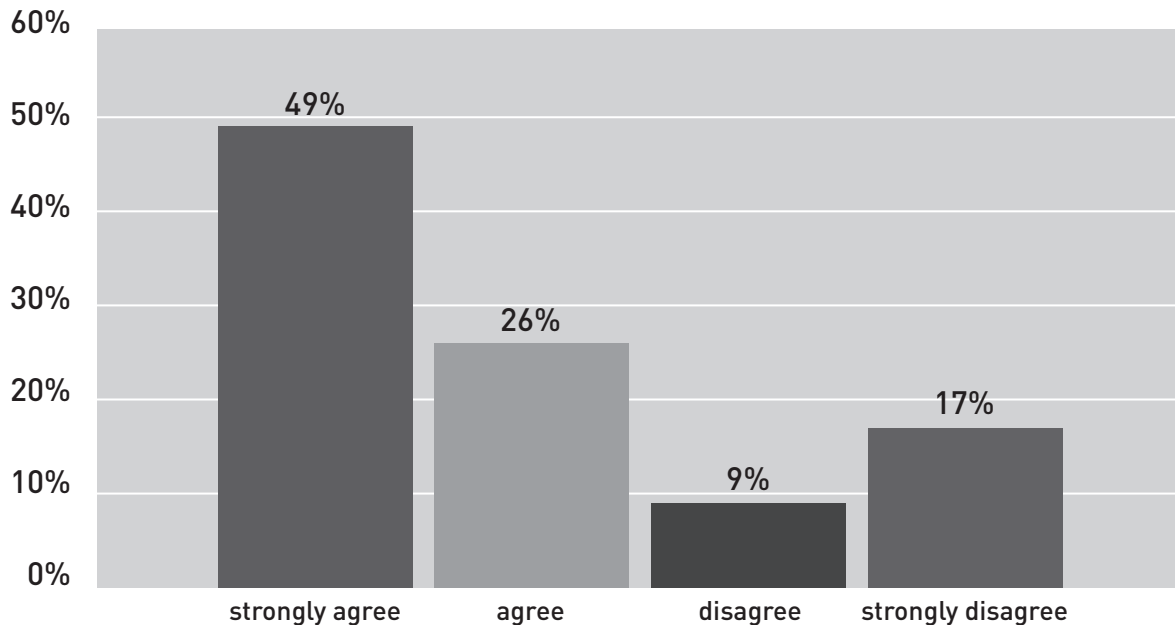
Survivors stated that since they were seeking counseling elsewhere, this prevented them from going to a rape crisis program.

“I had a counselor already, not rape crisis.”
—34-year-old female

Experiences with rape crisis counselors

Similar to other service sectors, just over half of respondents (53%) who sought services from a rape crisis/victim assistance program did so within the last three years. All survivors who sought services at a rape crisis program were asked a number of questions about their experiences with both the program and the rape crisis counselors. Most of these respondents (80.6%) ‘strongly agreed’ or ‘agreed’ that they could trust their counselor. Furthermore, Chart 8 shows the percentage of respondents that felt their counselor knew how to help them.

chart 8: I Felt My Counselor Knew How To Help Me



Respondents were asked if they were satisfied with the advice given to them on how to speak to their partners about the assault. Approximately half of the respondents said they were not satisfied with the advice given to them and a full third said that they were not given any advice when appropriate.

The majority of respondents (52.4%) said their counselors also gave them information about what to expect from the police, when this is a course of action they sought or considered seeking. A smaller percentage (42.1%) reported that their counselors gave them information about what to expect from the District Attorney, where applicable.

Survivors were also asked how comfortable they felt talking to the counselor about their experiences. The majority felt comfortable 'all of the time' or 'most times' (61.1%) with a small percentage (16.7%) stating that they 'never' felt comfortable speaking to their counselor.

As with other service sectors, survivors were asked if at any point they felt treated poorly at the rape crisis or victim assistance program and 22.9% (n=8) said they had. The top reasons for why they felt treated poorly were gender/sex, age and their difficulty in speaking English.

"I just felt that she didn't care. I was [a teen]...I don't think she had the knowledge or experience to deal with that." —32-year-old female

"lack of cultural competencies around alternative sexualities..."
—32-year-old transgender female to male (FTM)

"It was primarily for women" —54-year-old male

Overall, the overwhelming majority (74.3%) of survivors said they felt better as a result of their counseling experience. The majority of respondents (65.7%) felt 'very satisfied' or 'satisfied' with the emotional support that was provided by the counselor. Overall, a high percentage (68.5%) of the survivors in this study were 'very satisfied' or 'satisfied' with the rape crisis or victim assistance program they visited.

Survivor Voices:

What was the best thing about going to a rape crisis program?

"All of the support, sympathy, careful talking, kindness from all the staff...My counselor's availability to me...overall relationship with my counselor and the office manager/secretary."

—24-year-old female

"I feel like I'm taking steps to heal."

—25-year-old female

"Being told what to do to receive treatment and assistance. [My program] was very helpful, supportive, and I really appreciate everything they did for me."

—23-year-old female

"I felt heard and understood when I really needed help."

—34-year-old female

"Designing a program or structure with my counselor as a guide. Not only talking about the incident but also talking about me and my life to apply strength and confidence to areas that were weakened by the event and led up to the event. [My counselor] is the best! She is really good at what she does."

—30-year-old female

"They understand your history and are sensitive to your needs."

—36-year-old female

"Having someone to talk to and to help me through the process of working with the police, detectives and receiving compensation/coverage as I was uninsured at the time."

—33-year-old female

"My feelings and experiences were validated and I was comforted and reassured."

—57-year-old female

"I received the help I needed and the counseling sessions went deeper than the sexual assault. It helped me to see it wasn't my fault and that I am worthy of unconditional love."

—43-year-old female

"It was a safe space. Nothing I said, did or felt would shock them. My counselor knew about what I was feeling and what I would feel as time passed from the experience."

—28-year-old female

"Group counseling."

—31-year-old female

"How supportive and cared for I felt. This was the first time I felt like I could trust telling someone about my experiences and I also felt like I was really being helped."

—20-year-old female

"To let my feelings out and being able to vent and cry without being embarrassed or uncomfortable."

—53-year-old female

"The people really cared about my mental state and how I was feeling. They were also passionate about trying to change university policy. Although the rape crisis center was helpful, the office on campus (where sexual assault is reported and tried) was not."

—25-year-old female

Lesbian, Gay, Bisexual and Transgender (LGBT) Survivors: Navigating Through Heterosexist Systems

"The [Rape Crisis Program] did a great job. I found at the other programs that people were not able to deal with the particulars of the abuse, and my sexual orientation and gender identity."

—32-year-old transgender female to male (FTM)

The institutional level of heterosexism, built upon cultural norms, is high in our society. Given the invisible nature of heterosexism to heterosexuals, it usually comes as a surprise to realize how widespread it is (Girshick, 2002).

Homophobia, biphobia and heterosexism have major implications for service providers. Many social workers are not considering the full range of issues for their clients because they are not comfortable disclosing their sexual orientation (Appleby & Anastas, 1998 as cited in Girshick, 2002). Furthermore, survivors may perceive that therapists and other service providers are not open to sexuality issues or that they are insufficiently trained about human sexuality. Likewise health care providers and other service providers may make assumptions about heterosexuality and stigmatize patients by asking inappropriate questions. LGBT survivors may be further stigmatized by the false yet common belief that previous (especially childhood) sexual abuse resulted in their sexual orientation.

Rape, sexual assault, and related terms have the power to label some acts negatively, while ignoring and, by implication, condoning other acts. How these terms are defined affects how people label, experience, evaluate, and assimilate their own sexually coercive incidents. In addition, the definition of these terms convey numerous assumptions about power and coercion, sexuality, and gender. (Muehlenhard et al., 1992 as cited in Girshick, 2002).

In New York State, rape is defined as engaging in sexual intercourse by forcible compulsion or by engaging in such action with a person who is incapable of consent. "Sexual intercourse" has its *ordinary* meaning which is penis to vagina penetration and occurs upon any penetration, however slight. One of the major legal problems lesbians, bisexuals and gay men face is that oftentimes the state defines their sexual behaviors as illegal or deviant. Regardless of how these laws and definitions are enforced, that these "blue laws" are still on the books adds to the 'hostile environments in the courts' —(Hodges, 2002 as cited in Girshick, 2002).

Overall, heterosexism in the legal system can be found: in how sexual acts are defined and sometimes criminalized even when consensual; in gender neutral language that is not necessarily sexual orientation neutral; and when rape is not a charge applied for LGBT survivors and when it is, only at misdemeanor level (Girshick, 2002). This atmosphere discourages LGBT survivors from seeking protection and bringing the perpetrators to justice.

"Treat men who are raped the same way women are treated...it WAS rape even if I was not penetrated in the vagina...special sensitivity is needed to LGBT issues (hate crimes) and someone to talk to you and comfort you."

—54-year-old male

"I'm a sex researcher, and SM activist and a bisexual woman, and he was a bisexual man. We are both black. The DA's office doesn't give a shit about black women, particularly black women who won't be victims.." —44-year-old female

Survivor Voices:

What was the worst thing about going to a rape crisis program?

“Dealing with the reality of the crime.”

—44-year-old female

“I felt judged.” —26-year-old female

“Having to face what happened to me.”

—26-year-old female

“I didn’t have an advocate to help me get through this pain of how to talk to the police or detective about the rape.”

—35-year-old female

“It was primarily for women.”

—54-year-old male

“It’s difficult to disclose information to strangers about something so personal and traumatic.”

—25-year-old female

“The fact that it was short-term.”

—20-year-old female

“Lack of understanding, lack of culturally competent services.”

—32-year-old transgender female to male (FTM)

“They never followed up.”

—31-year-old female

“It is only short term...a year at the most. If you want to continue therapy you have to find a new counselor.”

—28-year-old female

“Naturally it was difficult to talk about.”

—57-year-old female

“Getting there...I’d procrastinate and put off appointments.” —24-year-old female

“The limits people put on assistance due to lack of paperwork, i.e. police reports, hospital reports, RO’s, etc. When my life would be threatened and possibly terminated if these reports were obtained against my attackers.”

—36-year-old female

“She didn’t care. No one seemed to. It was as though it was a joke to people.”

—32-year-old female

“Probably that I had to pay a fee...”

—41-year-old female

“They did not seem to have much information. I emailed [a women’s organization] and they never responded, so I gave up on organizations.”

—28-year-old female

“Rehashing all the terrible details/memories.” —25-year-old female

Too hurried, too rushed, my problem and/or situation was too enormous or better yet too profound for her to handle. I was treated with an impatient, disinterested attitude” —41-year-old female

Survivors' Recommendations

Twenty-three survivors gave recommendations to help make rape crisis and victim assistance programs better for other survivors.

1. More training for counselors

Several survivors mentioned that more training should be provided to the rape crisis counselors to better help survivors.

"Better trained staff and assistants who are prepared to handle such case sensitive clients and information. People who lack empathy have no business working in areas of such sensitive nature." —41-year-old female

"Have better understanding counselors..." —32-year-old female

"More services for transgender clients, more awareness about alternative sexualities including BDSM." —32-year-old transgender female to male (FTM)

"...not to make male-on-male rape taboo." —54-year-old male

2. Have connections to and provide other services for survivors

Many respondents mentioned that there need to be referrals and connections made from rape crisis programs to other services, especially safe housing.

"Add legal services." —23-year-old female

"Immediate safe shelter/housing set aside for victims of violence and sexual abuse. Based on counseling history, which is often free and confidential and does not impose an immediate vulnerability attack to victims such as myself." —36-year-old female

"Need to have a connection to help victims of domestic violence and make housing better than it is. You stay in Tier II too long or Tier I

too long and people go back to their batterer. This isn't good!" —53-year-old female

"[There is a] lack of shelters and safe houses that are accessible..." —55-year-old female

3. More group therapy

One recommendation for improving services was to offer more group therapy for survivors of sexual violence.

"Group therapy could be valuable and interesting." —30-year-old female

"More group sessions throughout the year." —26-year-old female

4. Offer long-term counseling

Many respondents mentioned that one way to improve services for other survivors would be to have more long-term counseling.

"I would make sessions longer." —20-year-old female

"The program is an excellent program, maybe more time and more sessions." —43-year-old female

5. Offer free services

It was mentioned that one thing that could be improved for other survivors is to offer counseling services at no charge to survivors.

"That they would accept medical insurance or give free services for financially challenged survivors of sexual assault." —41-year-old female

“The officer was helpful and took me seriously.” —44-year-old female

Chapter 4: Law Enforcement

One option available to sexual assault survivors after an assault is to report to the police. Many survivors report the crime to the police to apprehend the perpetrator in order to feel safer and more empowered. Many survivors also choose not to report to the police.

This study assessed the following with regard to law enforcement: **1)** what prevents survivors from going to the police, **2)** the specifics details of their contact the police, **3)** experiences with the police, **4)** treatment by uniformed officers, **5)** treatment by non-uniformed officers, **6)** satisfaction with the police, **7)** the positive and negative aspects of reporting to the police after a sexual assault, and **8)** recommendations for improving the law enforcement response to sexual assault. This chapter also includes information on male survivors of sexual violence as an underserved population.

Law Enforcement

All police officers of the New York City Police Department (NYPD) are trained how to respond to sexual assault cases. Furthermore, specialized response is available through the Special Victims Division. In 1972, the NYPD started the Rape Hotline to respond to cases of sexual violence. A couple of years after the Rape Hotline was initiated, each borough instituted Sex Crimes Units to work on these cases locally. Only in January 2003 was a Special Victims Division created, with each borough squad reporting to a citywide command that works directly under the Chief of Detectives. Staten Island does not have a Special Victims Squad at this time but detectives assigned to the borough receive the same training. 911 operators also receive training by the Special Victims Division on telephone communications, rape trauma syndrome, domestic violence, and counseling resources available to survivors.

Detectives in the Special Victims Division all attend a week-long Sex Crimes and Child Abuse Investigation Course given by the Special Victims

Division that is accredited by the State University of New York. The course consists of approximately 25 lessons from leaders in the field of investigating and prosecuting sex crimes, and always opens with a compelling story of a survivor to emphasize the need for empathy. Each year five or more Special Victims detectives are invited to attend the Sex Crimes Course given by the New York State Troopers, and when available investigators attend other related conferences.

According to the NYPD Academy, the role of the first-response uniformed police officer in a sexual assault case is not investigative. They are there primarily to provide aid to the victim (Police Academy, 2006). The Recruit Training Section Student Guide explains that the first police officer on the scene of a sex crime plays an important part in minimizing the trauma and in maximizing the chances of successful prosecution. In the sex crimes cases, police officers are taught to recognize that the victim is probably suffering the most traumatic experience of his/her life and to therefore, demonstrate extreme patience, compassion, and understanding in these encounters.

A uniformed police officer is often called in first response on a case of sexual assault. The detectives, regular or Special Victims, are called in later and often arrive at the hospital emergency room after the survivor's arrival. In cases where uniformed officers are not involved, the police may be notified by the hospital if the survivor wishes to report. When this happens the detectives may be the first response officers. In either case, the role of the detective is in many ways quite different from the role of the uniformed officer. One of the primary goals in the investigation of an adult sex crime is the identification and arrest of the perpetrator.

In the Detective Bureau, investigators are given the Executive Laws that require that a private setting be used for an interview with a sex crime victim,

and that allow a rape crisis counselor (advocate) to be present during an interview, unless the victim objects. The detective procedure includes fifteen points (prior to apprehension) beginning with the interview of the first responders as well as the victim, and obtaining medical attention for the victim. The other points are concerned with the proper collection and handling of evidence (Lt. S. Clark, personal communication, September 4, 2006).

Since the police officers work in direct contact with victims, it is important for them to have the capacity to understand multiple languages. In March 2004, the Language Line Program was launched, which equips all police precincts with direct, instant access to language interpreters 24 hours a day. Each precinct stationhouse has special dual-handset telephones with access to interpreters in over 150 different languages. Now victims who do not speak English can tell their stories to the police and get the help they need. Since the inception of the program, Language Line phones have been used over 1,000 times in over 30 languages including: Arabic, Bengali, Cantonese, Farsi, Greek, Haitian-Creole, Hindi, Japanese, Korean, Mandarin, Punjabi, Russian, Spanish and Urdu (OCDV, 2004).

The implementation of a Special Victims Division and other services such as the Language Line are important enhancements for survivors of sexual violence during an investigation.

Examining satisfaction with the police

Recently, policing research has focused more on improving community relations and improving citizen satisfaction with police services. In a National Institute of Justice study, *Satisfaction with Police—What Matters?*, authors found that three factors influenced satisfaction: **1)** encounters with the police, **2)** perceived neighborhood quality of life (including feelings of safety), and **3)** neighborhood context (Reisig & Parks, 2002). While police can do little to directly change the perceived neighborhood quality of life, which varies between individuals, administrators are focusing more on citizen interactions with the police as a quality improvement measure.

One study found that people were more satisfied when officers were respectful and met or exceeded service expectations, such as explaining their course of action (Furstenburg, 1973 as cited in Reisig & Parks, 2002). As with measuring satisfaction in other service sectors, satisfaction most often results when expectations are met or exceeded. The question then becomes, what are survivors' expectations when interacting with the police after a sexual assault? Previous research has shown that most citizens expect police to behave in a professional manner, specifically avoiding sarcasm and acting courteously and respectfully (Reisig & Parks, 2002). Several questions were asked in this study to measure satisfaction with interactions with the police. It is clear from this study that survivors expect to be kept informed about the process of their case and what to expect. Furthermore, survivors expected explanations for why certain questions needed to be asked.

Research Questions and Findings

What prevents survivors from reporting to the police?

To better understand the decision-making process, survivors who did not go to the police were asked, "Was there anything that prevented you from going to the police?" Fourteen survivors mentioned several main themes about why they did not go to the police.

- **Afraid of how police officers would treat them**

Survivors expressed that fear of how they would be treated was a deterrent to seeking help with the police.

"I'm hesitant to file a report, because I'm afraid to be asked questions that make me uncomfortable. I have selective memory of the night of my assault and am missing essential minutes, where I don't know what happened. I'm afraid the police won't believe me. The person who assaulted me lives in my neighborhood, and knows where I live; and I see him on the street every now and then. I'm afraid to have to face a confrontation with him, if I file a report." —34-year-old female

"...the domestic violence, fear of prejudice against LGBT folks, fear that they would remove children,

just wanting to get out of the abusive situation.”
—32-year-old transgender female to male (FTM)

“..because I just wanted to get a medical examination and also because I was afraid I would be treated as an instigator...”
—50-year-old female

- **Past negative experience with the police**

Survivors expressed that having past negative experiences with the police also prevented them from seeking help from the police after a sexual assault or continuing to seek help from the police.

In the survey, respondents were asked about prior negative experience with the police. The responses were split fairly evenly between those who did not (57.6%) and those who did 42.4%. However, prior negative experiences did not significantly impact satisfaction with the police response by either the uniformed or non-uniformed officers.

“I did call the police the night I was attacked. However, when the police arrived at my apartment that very same night, one of the officers promised that my underwear I was wearing at the time of my assault would be picked up the next day by another officer at my neighborhood precinct. The officer, however, failed to show up for some reason or other, so I didn’t bother to go to that police precinct.” 41-year-old female

“My attacker was a police officer.”
—20-year-old female

- **Not wanting to get involved in the criminal justice process**

Survivors expressed that not wanting to get involved in the criminal justice process prevented them from going to the police after the sexual assault.

“I didn’t want to arrest my best friend.”
—26-year-old female

“I did not want to get embroiled in anything legal. I did not feel the assault was dire enough to report, I suppose.” —21-year-old female

- **The trauma of the sexual assault**

For some survivors the trauma of the sexual assault and the characteristics of the assault prevented them from going to the police.

“I was confused about my assault. I had been drinking. However, now I know I was slipped a date rape drug.” —26-year-old female

“In the beginning I was catatonic, frozen in shock, hurting, cold, severely traumatized and in extreme pain, and since there was such a violent counter-attack I was very much afraid as well.”
—41-year-old female

- **Other reasons**

Several other reasons for not reporting to the police mentioned included lack of knowledge and access.

“Didn’t know it was my right.”
—25-year-old female

“Wheelchair access and nobody taking me seriously.” —55-year-old female

Help-Seeking Behavior

Over half (49.2%, n= 32) of the respondents contacted security or police after the sexual assault. For those that did report to the police after the sexual assault, questions were asked about how they contacted the police. The police were most likely to be contacted by the survivor themselves (64.3%), as opposed to a friend (14.3%), family member (7.1%) or stranger (7.1%). Most often the police were contacted through dialing 911 (81.5%) and a smaller percentage were contacted through going to a local police station (14.8%).

The majority of respondents who contacted the police did so within a day of the assault (77.4%) and a much smaller percentage contacted the police within two weeks after the assault (12.9%). For nearly two-thirds of the respondents, the police were called during the day (from 8am to midnight) and a smaller percentage (30%) was contacted during the night (between midnight and 7:59am) when it is more likely that the nightwatch will be the first responders. Several respondents didn’t recall when the police were called.

Survivor Voices:

What was the best thing about going to the police?

"They were the best. I will always remember [the two detectives]. They worked their butts off on this case. They truly cared. And I will thank them EVERYDAY for that." (emphasis original)

—32-year-old female

"Addressed crime quickly...rapist immediately arrested, DA contacted immediately, she called me that weekend. Uniform female officer [was] extremely supportive and non-judgmental."

—24-year-old female

"Being free to speak my mind about what had happened to me."

—41-year-old female

"They believed me and were basically nice to me." —54-year-old male

"Feeling safe." —44-year-old female

"It helped me to gain a sense of control and safety. And 8.5 years later, as a result of a DNA match that wouldn't have been collected if I had not gone to the hospital/police, we just put him away!"

—33-year-old female

"They told me exactly what I could do."

—31-year-old female

"..A detective went the extra mile to make me comfortable. He is the best! They really responded to catch him after I spotted him 3 weeks later. They did instruct me at the time of the incident to keep

my eyes out for him, and I listened and caught him 3 weeks later."

—30 year old female

"The officer was helpful and took me seriously." —44-year-old female

"The police were very helpful to me. They also drove me home from the station and picked me up the next morning to go to get a restraining order against the man who assaulted me. I also ran into the arresting officer later in the subway when he was in plainclothes. It made me feel good to see him." —32-year-old female

"They arrested the guy."

—26-year-old female

"They drove me home from the scene. I felt safe and I felt like maybe they could prevent a similar incident from taking place with another person."

—34-year-old female

"They called the ambulance to take me to the hospital." —36-year-old female

"They really worked hard to try and find the perpetrator. I felt safer when they arrested him." —25-year-old female

"They were kind when taking my statement." —23-year-old female

"They treated me with respect and sensitivity." —female (age not given)

Experiences with the police

Survivors were asked several questions about their experiences and interactions with the police. On average survivors recounted the details of the sexual assault to three police officers, ranging from telling one officer to talking to 12 police officers. For some people, recounting details over and over again can be very traumatizing.

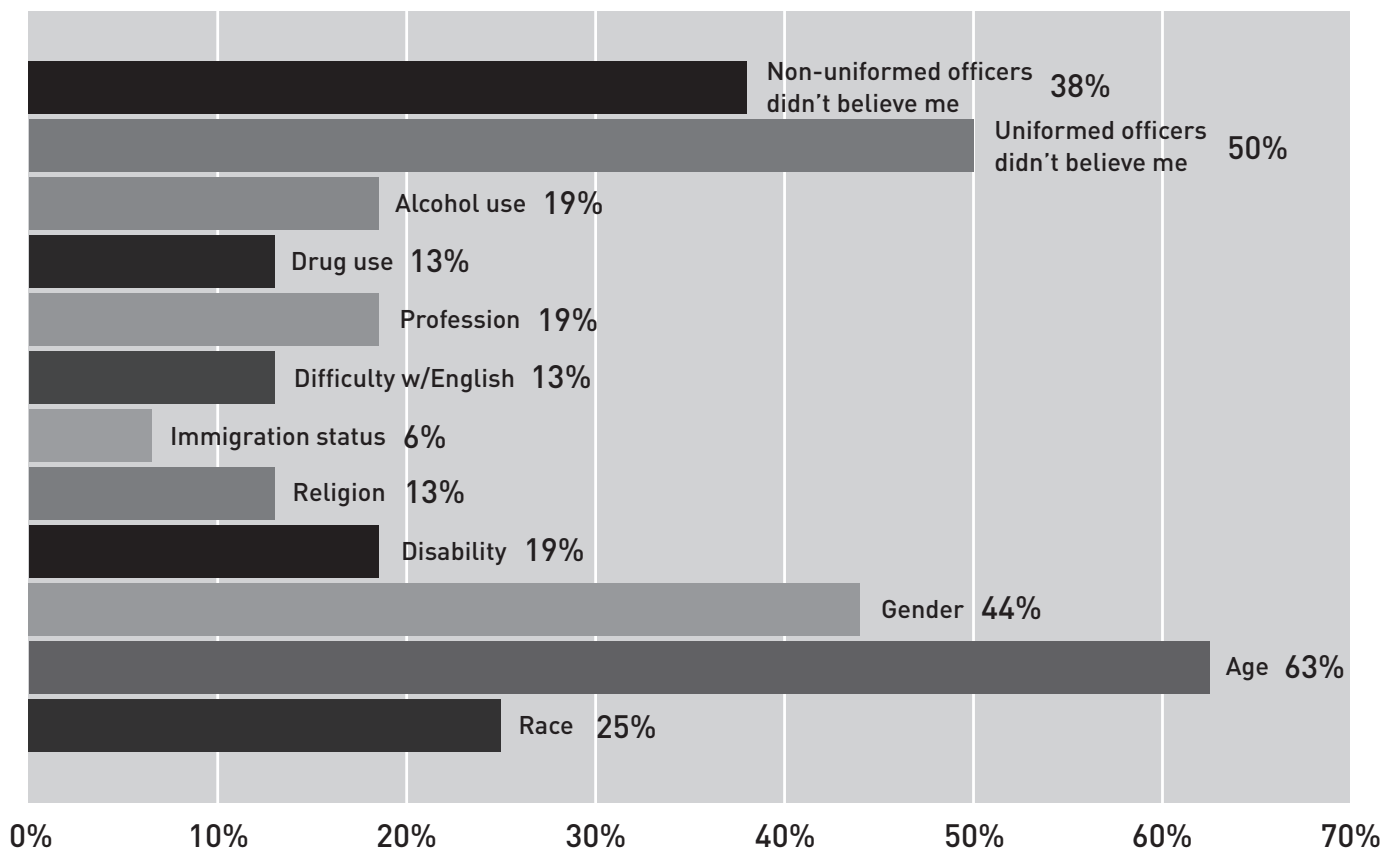
There were also very few referrals to counseling services, support groups or rape crisis programs. Only 29% of survivors said that any police officer gave them this information. Referrals for services such as counseling are very important to address the continuum of care and ensure that holistic care is being provided.

Survivors were also asked if they felt treated poorly by the police at any time. Just slightly over half (51.6%) or sixteen respondents said they did feel

poorly treated at some time. However, the majority of respondents were either 'satisfied' or 'very satisfied' with both their treatment by uniformed officers (78%) and by non-uniformed officers (57%). Chart 9 shows several reasons these survivors thought contributed to their being poorly treated by the police.

For these survivors, age was the main reason cited (62.5%). These responses came from a wide age range of survivors but were mostly concentrated in women in their 20's and 30's. Survivors also felt that the uniformed officers did not believe them (50%) much more than the non-uniformed officers (37.5%). Many felt that their gender also contributed to poor treatment (43.8%). While data limitations prevented further analysis of these answers, one area for future research is to explore these feelings in greater depth.

chart 9: Reasons for Feeling Treated Poorly by the Police



Treatment by Uniformed Officers

The survey made the distinction between uniformed officers and non-uniformed officers. Uniformed officers tend to be the first responders and on-duty police officers. Non-uniformed officers tend to be detectives and undercover police officers. A distinction was made to offer more detail to the accounts and recommendations.

Of those who went to the police, 87.5% (n=28) spoke with an officer in uniform. Overall, the majority (70.3%) of respondents felt 'satisfied' or 'very satisfied' with the explanation given to them by the officer in uniform about why certain questions were being asked. Furthermore, nearly half of the respondents felt that the officer in uniform made efforts to address their safety concerns (46.4%).

Treatment by Non-Uniformed Officers

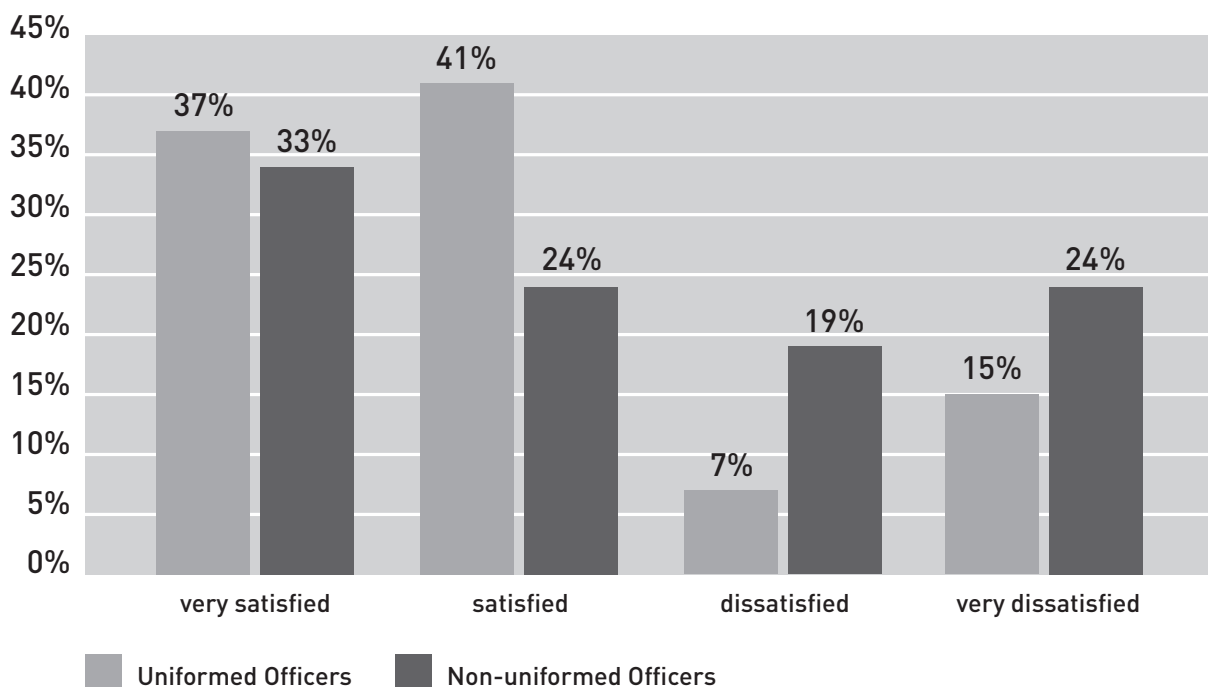
Fewer respondents who went to the police reported speaking with a non-uniformed officer (65.6%) after the sexual assault. Among them, over half (60%) reported feeling 'satisfied' or 'very satisfied' with the explanation given to them by non-uniformed offi-

cers about why certain questions were being asked; however, a quarter of the respondents felt 'very dissatisfied' about the explanation given to them by the non-uniformed officers. A similar percentage of non-uniformed officers (47.6%) reportedly made efforts to address the survivors' safety concerns as that of uniformed officers (46.4%).

Chart 10 shows the respondents' satisfaction with the way they were treated by uniformed and non-uniformed police officers. The majority of respondents were either 'satisfied' or 'very satisfied' with both their treatment by uniformed officers (78%) and by non-uniformed officers (57%). A higher percentage of respondents were either 'dissatisfied' or 'very dissatisfied' with their treatment by non-uniformed officers (43%) than by uniformed officers (22%).

Nearly two-thirds of respondents (61.9%) who worked with non-uniformed officers felt that the officer did not make efforts to keep them informed as the investigation continued. Furthermore, a little over half of the survivors (52.4%) felt that the non-uniformed officer did not give them information about what to expect during the investigation.

chart 10: Satisfaction with Treatment by Uniformed and Non-Uniformed Officers



Case Study: Male Survivors of Sexual Assault: The Hidden Epidemic

"We are primed and ready to recognize male perpetrators but turn a blind eye to male victims." —from "The Male Survivor: The Impact of Sexual Abuse by Mendel (1995, pg.4).

All men are potential victims of sexual assault (Lipscomb et al., 1992). According to national statistics, 2.8 million men in the United States were forcibly raped at some time in their lives. The majority of male victims (70%) were raped before their 18th birthday. Male victims tend to be raped by acquaintances, regardless of their age at the time of the victimization (Tjaden & Thoennes, 2006).

Help Seeking Behavior

Male rape and sexual assault is even more underreported than female rape. Researchers and practitioners believe this results from: **1)** social beliefs that men are expected to be able to defend themselves against assault (McMullen, 1990; Ashworth, 1995 as cited in Rentoul & Appleboom, 1997), **2)** the survivor's fear that his sexual orientation may come under critical scrutiny, **3)** reporting male sexual assault is distressing (Groth & Burgess, 1980 as cited in Rentoul & Appleboom, 1997), and **4)** the 'male ethic', which emphasizes self-reliance among men (Stank & Hobdell, 1993; Mendel, 1995 as cited in Rentoul & Appleboom, 1997). Furthermore, male victims of rape and sexual assault feel poorly understood and find it very difficult to report the crime and seek help (King, 1995; Mezey & King, 1987; Holmes, 1989 as cited in Rentoul & Appleboom, 1997).

When they do seek help, men are most likely to go to a rape crisis or victim assistance program. A study that examined agencies that treated men for sexual assault found that 61% of the agencies were rape crisis programs and the second highest

number of survivors was seen at victim services in the District Attorney's office (Isely & Gehrenbeck-Shim, 1997). Male survivors are likely to contact these services much later after the assault. A study conducted with a male-focused counseling program in London found that the average time from assault to contact with the counseling program was 16.4 years (King & Woollett, 1997). In the current study when asked about their experiences with rape crisis programs, two male survivors wrote:

"It was primarily for women."

"It was not expected that a man would seek counseling for rape."

In a study of 3,635 male sexual assault survivors, it was found that when men sought medical treatment, only 23% revealed the sexual nature of their assaults to the medical personnel. In this same study, very few men (15%) reported the assault to the police —(Isely & Gehrenbeck-Shim, 1997).

Men are often prevented from seeking help because they feel they will not be believed. It is particularly important for service providers to recognize that the events occurred and to accept the survivor and provide support. When asked what he would change about the hospital system to make it a better place for other survivors, one man said:

"privacy, information, referral...AND IT WAS RAPE EVEN THOUGH I AM A MAN."
(emphasis original)

Another respondent mentioned:

"Treat men who are raped the same way women are treated...it WAS rape even if it was not penetrated in a vagina." (emphasis original)

Survivor Voices:

What was the worst thing about going to the police?

"I had to answer questions that I was not comfortable with." —34-year-old female

"It was very uncomfortable. When I called 911 I spoke with a woman, who was not very nice. When I went to the station, I had to speak with a man."

—25-year-old female

"I was not believed. No attempt to help me really came. No information on my case. Detective did not keep me informed on what's going on. I felt like I had been victimized all over again."

—35-year-old female

"Telling the story of what happened. It was intimidating." —24-year-old female

"...the treatment I received from NYPD was reprehensible; I was verbally abused and highly disrespected to the point of severe insult and humiliation."

—41-year-old female

"fear of rejection." —44-year-old female

"I was lied to about the action not being taken against the rapist. They promised to make an appointment for me with a DA and failed to do so." —23-year-old female

"The abuser is a police officer that was defended by the department."

—36-year-old female

"They took like 20 minutes and I felt unsafe, they didn't want to drive me home..." —22-year-old female

"crime victims on city jobs need protection and rights about making police complaints..someone outside city jurisdiction who does not work for DC37 needs to be monitoring and protecting us."

—43-year-old female

"...the sense that you were being a nuisance when calling for information on the investigation. Having to discuss very personal details with strange men."

—28-year-old female

"Their inability by choice to take me to the emergency room that night because the rape was incomplete." —41-year-old female

"They called it sodomy at the hospital in a public place and in a loud voice without sensitivity."

—54-year-old male

"They made me feel like I put myself in the position to be assaulted, they were somewhat condescending."

—25-year-old female

"...no female detective; it would have been easier to speak to a gay or lesbian officer. That said, this experience made me think much more highly of the police than I had before." —44-year-old female

"...They made promises they did not keep regarding evidence, gave me the run-around, did not return calls, [and] would not communicate with the DA. I felt like my case [was] unimportant compared to others." —28-year-old female

Survivors' Recommendations

Twenty-five survivors gave recommendations to help make the police response better for other survivors.

1. More training for police officers

Overwhelmingly, survivors recommended more training for police officers on interacting with survivors. Specifically, it was mentioned that police officers should receive training in interviewing skills that include victim sensitivity, handling emotions, and general interpersonal communication skills. Also, a recommendation was made for police officers to use the manuals from the National Organization on Disability on the Uniform Duties to Disabled Persons law.

"Detectives need to be better trained to handle emotion." —26-year-old female

"They need to have officers, especially the men, trained in sensitivity...for victims of sexual abuse and violence, and ask that upon interviewing people they present this as their first form of communication." —36-year-old female

"The police should be better educated, and they should be required to take classes in ethics and psychology." —37-year-old female

2. Provide referrals for other services

Many survivors mentioned that to make police services better for other survivors, it was important that police provide referrals and information for other services such as counseling.

"That they should listen to survivors' requests for help of their choosing and accede to it."
—41-year-old female

"They could have ...offered me the location of a support group or number..."
—28-year-old female

3. Treat sexual assaults as a serious crime

Several respondents stated that in order to make services better, it is important for police officers to treat sexual violence as a serious crime and act more concerned when interacting with survivors.

"...calling it rape and not treating it as just businesslike." —54-year-old male

"They could have seemed more concerned...and treated this like a serious crime."
—28-year-old female

"...make them nicer for Christ's sake I was almost raped!!! And they acted like it was nothing. I know it happens everyday, but I'm still a human being."
—22-year-old female

4. Police officers should ensure more privacy for survivors

Many survivors mentioned instances involving a lack of privacy when disclosing details about the sexual assault. Police should interview victims in private.

"They yelled out sodomy at the hospital in a routine way." —54-year-old male

"Remove perpetrator from room..."
—53-year-old female

5. Have more female officers handle sexual assault cases

Many survivors mentioned that having female officers and detectives would make the experience better for other survivors.

"More female detectives would be nice."
—44-year-old female

"First of all, I would not have male officers handling female rape victims before [or] after, they have no respect or regard to the handling of these cases." —41-year-old female

"More female police officers to handle this situation...it's difficult and embarrassing to discuss this with a male stranger."
—32-year-old female

“I wanted to press charges and did. Even though I felt it was a lost cause. I felt that I needed to do it for me and for the progression of this fight.”

—25-year-old female

Chapter 5: Criminal Justice

Prosecuting perpetrators of sexual violence is, unfortunately, a very difficult process for both the prosecutor and for the victim. Navigating the criminal justice process often occurs after a survivor of sexual assault has already accessed other services. It is very rare that the criminal justice system is the first point of contact for survivors of sexual assault. As a result, a smaller percentage of the sample in this study (34%, n=22) went to the District Attorney's office. Due to the small numbers it is difficult to draw reliable conclusions, thus results should be interpreted with caution.

This study assessed the following with regard to the criminal justice system: **1)** what prevents survivors from going through the criminal justice process, **2)** case characteristics of survivors in this study, **3)** experiences with prosecutors, **4)** satisfaction with criminal justice system, **5)** the positive and negative aspects of going through the criminal justice system, and **6)** recommendations for improving the criminal justice system for other sexual assault survivors. This chapter also includes information on survivors with physical disabilities as an underserved population.

Criminal Justice Services

Each borough in New York City has a District Attorney's (DA's) office that has the responsibility and authority to investigate and prosecute crimes in that borough. Sexual assaults are among the most under-reported crimes in the United States (NYDA, 2006). The prosecution of such cases is difficult and demands considerable expertise. In 1974, the New York County District Attorney's Office, recognizing the need to dedicate resources and special attention to crimes of sexual violence, became the first prosecutor's office in the nation to establish a sex crimes prosecution unit (NYDA, 2006). A Sex Crimes Unit now exists in each of the DA's offices in the five boroughs.

In addition to prosecutorial process, members of each of these units spend a great deal of time training medical personnel about protocols for victim examinations, providing training to police about case investigation techniques, and informing the public about sex crimes (NYDA, 2006). Prosecutors all over the state and country have followed the Sex Crimes Unit model that was started in NYC.

Each of the Sex Crimes Units work closely with the NYPD's Special Victims Squad, frequently interacting with detectives from the moment a rape case is reported to the police. Furthermore, DNA technology has revolutionized the investigation of sexual assault cases. DNA databanking has the potential to solve scores of cases in which investigators were initially unable to identify the rapist.

Each of the DA's offices also offers counseling services to survivors of sexual assault both for the initial crisis and through the often difficult components of the criminal justice process. In addition, many of the DA's offices provide additional specialized services for adults. The Kings County District Attorney's office in Brooklyn has instituted three such programs:

Barrier Free Justice, started at the Kings County (Brooklyn) District Attorney's Office in 2000, assists survivors of any crime with psychiatric, physical, or cognitive disabilities to navigate the criminal justice system. A network of involved social workers, case managers, and attorneys provide guidance, support, and concrete services to facilitate the victims' steps toward safety (Barrier Free Justice, 2006).

Project Shield is a collaborative effort between the Brooklyn District Attorney's Office and YAI/National Institute for People with Disabilities. The aim of project shield is to educate professionals about the sexual assault of individuals with Mental Retardation/Developmental Disabilities (MR/DD). This training project has a goal of facilitating more effective investigations and prosecutions of sex crimes involving individuals with MR/DD through collaboration between criminal justice professionals, social service providers and community groups (Project Shield, 2004).

The Brooklyn **E.P.I.C. (Ending Prostitution in our Communities)** is a six-week alternative-to-incarceration program for individuals arrested for prostitution-related offenses in Brooklyn. The E.P.I.C. program is offered to individuals twenty-two years old and over arrested out of the 60th and 72nd precincts. The current program goals are to reduce the number of people engaging in prostitution and to decrease recidivism; increase economic self-sufficiency; and improve physical and mental health (K. Kramer, personal communication, July 28, 2006). While this program does not specifically focus on sexual violence, it does recognize that prostituted women often need rape crisis and related medical services. There is also a similar program called S.T.A.R. which was developed by District Attorney Charles J. Hynes to assist teens to abandon prostitution by providing them with concrete alternatives and solutions (Brooklyn DA, 2007).

Measuring satisfaction with criminal justice services

Measuring satisfaction with the criminal justice system is challenging. Unlike some sectors, the DA's office does not provide direct services to the client; instead they represent the state in a case against the perpetrator. The mandate of the

criminal justice system is to fairly adjudicate criminal applicants, promote community safety and uphold the law. The role of an attorney in a civil case differs from that in a criminal case; in civilian cases, there is direct client representation.

Since satisfaction is measured as exceeding expectations, the question becomes what do survivors expect from prosecutors in the DA's office? Going through the criminal justice system is no easy task and to provide survivor support, many of the DA's offices have set up victim advocacy services. While this study asked about survivors interactions with victim advocates at the DA's office, the small number of respondents precluded their inclusion in this report.

Similar to the police sector, there is little prosecutors can do to change satisfaction with the outcomes of the case. They can, however, behave in a professional manner and act respectfully toward survivors. Understanding survivor expectations will help prosecutors to develop victim advocacy services and educate the public about their role in sexual assault cases.

Research Questions and Findings

What prevents survivors from seeking criminal justice services?

To better understand barriers to accessing the criminal justice system, survivors were asked "Was there anything that prevented you from going to the District Attorney's office?" Four main themes emerged from their responses:

- **Lack of information about the criminal justice process**

Survivors mentioned that they did not know that going to the District Attorney's office might have been an option for them.

"I didn't know anything about this. That I could talk to or contact the District Attorney's office."
—35-year-old female

"I don't know how, and it's too late to prosecute the rapist. All the physical evidence is gone."
—37-year-old female

"Not given the option." —54-year-old male

- **The perpetrator was never caught**

Many survivors said the fact that the perpetrator was never caught prevented them from going to the District Attorney's office.

"Because the man who violated me was a total stranger whom I didn't know by name (although I had a fairly good description of what he had worn as well as where the attack occurred the night the attack happened). Furthermore, because the assault was incomplete, I figured that the District Attorney couldn't do much as I had encouraged the police to try to find the guy and when they couldn't after about a month, I just gave up on the case." —41-year-old female

"Couldn't find the perpetrator and not suggested."
—54-year-old male

- **Charges were not filed against the perpetrator**

Survivors expressed that one of the main reasons they did not go to the District Attorney's offices was that they either did not know charges needed to be filed or they did not want charges to be filed against their attacker.

"I called the DA's office in NYC to ask for advice. They told me I needed a docket number to speak with an assistant DA. I again asked if I could seek advice and they told me that I had to file charges." —26-year-old female

"I didn't want to file charges against my best friend." —26-year-old female

"...no report was taken. So no report [was sent to] the District Attorney." —55-year-old female

- **Difficulties in contacting District Attorney's office**

Some survivors experienced difficulties when trying to reach the District Attorney's office, either through an intermediary or directly.

"I was given the phone number of a DA, and we left messages on each other's cell phone, but never got to talk to each other in person."
—34-year-old female

"Police said they'd set up an appointment for me, and then would not do so, I was given no contact information." —23-year-old female

Case Characteristics

Only 34% of respondents in this study went through the criminal justice system after the sexual assault (n=22). Of those, the majority went to the DA's office within a week of the assault occurring (52.6%) and over a quarter went within a month (26.3%).

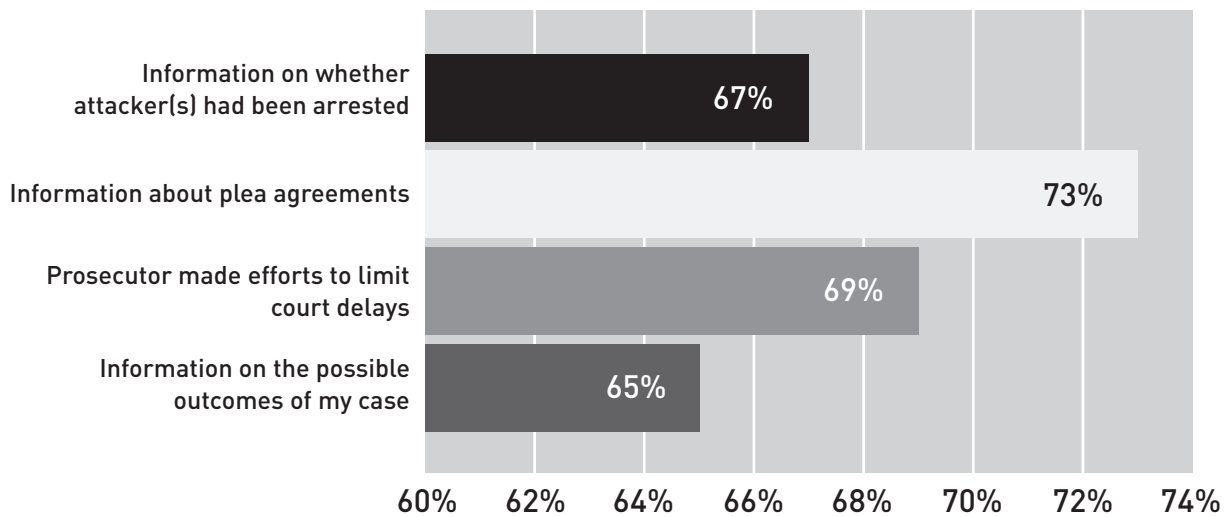
For those who reported going through the prosecution process, the timeline for prosecuting the cases for the majority of respondents was less than six months (44%), between six months and one year (31%), and longer than a year or ongoing (12.5% each). When asked about the final outcome of the case, 38.1% ended in convictions (28.6% plead guilty and 9.5% by trial). Nearly a quarter (23.8%) of cases were dropped or dismissed, and 19% are pending. One respondent mentioned the outcome of her case:

"Defendant was deemed mentally incompetent to stand trial and reprimanded [sic] to social services." —32-year-old female

Experiences with the prosecutors

Survivors were asked several questions about their experiences and interactions with the prosecutors at the District Attorney's office. The majority of respondents (65%) were either 'very satisfied' or 'satisfied' with the way they were treated during the first interview. Chart 11 shows whether the respondent received information on various aspects of the

chart 11: Information Received About the Criminal Justice Process



criminal justice process. Nearly three-quarters of the respondents received information about plea agreements (73%) and reported the prosecutor made efforts to limit court delays (69%). The majority of survivors also reported that they were given information whether their attacker(s) had been arrested (67%) and information on the possible outcomes of their case (65%).

A small percentage of respondents (36.4%) testified in court against their attacker. Of those that testified, 60% were 'very satisfied' with the information given to them about testifying in court and 77.8% felt well-prepared to testify.

Five respondents wanted to press charges but felt that after going to the District Attorney's office that they could not. When asked why they felt this way, several survivors responded:

"The DA basically told me there was not enough evidence to prosecute and this made me feel like the perpetrator had won and nobody believed me and all my efforts to empower myself were in vain." —25-year-old female

"The DA kept trying to talk me out of it, saying that because there were no witnesses, and because of the defense attorney's experience, they would make me look like a fool."

—29-year-old (gender not given)

"The first DA that I spoke with interrogated me as if I were a criminal and asked me why I did not fight back harder, why did I let this guy do this to me. SHE was very insensitive and rude, basically reduced me to tears, and kept leaving the office and interrupting our interview with phone calls and other appointments, even though she had made an appointment with me."

—28-year-old female (emphasis original)

Survivors were asked if they felt poorly treated at the District Attorney's office and the reasons they felt this way. Ten respondents, or less than half of the survivors (45%) who reported going to the District Attorney's office, said that at some point they felt poorly treated. Of these survivors, the major

reason reported for poor treatment was they felt that their prosecutor did not believe them. Several respondents explained other reasons why they felt treated poorly:

"The A.D.A. told me she was too busy with more important cases." —26-year-old female

"She didn't give a damn. She plea-bargained the case without notifying me that she was going to so, and she let a known stalker loose so he could become a counselor." —44-year-old female

"Insensitive/stoic behavior all around." —36-year-old female

Survivor Voices:

What was the best thing about going to the District Attorney's office?

"The chance to make this crime known."
—36-year-old female

"Prosecutor was serious, organized, detailed, determined, honest and professional. I was compensated for my time and reimbursed for doctors/hospital bills. Pictures of bruises were taken."
—24-year-old female

"Justice." —44-year-old female

"That even though they weren't punished fairly and were treated like privileged white men, they were still held accountable and publicly plead to the charge." —25-year-old female

"She [the ADA] knew what she was doing."
—53-year-old female

"They were just like the police—very helpful and caring. I will always be forever grateful to [my prosecutors] for all their hard work."
—32-year-old female

"My DA. She is incredible. So thorough and solid—she prepares you, calms you and works so hard." —33-year-old female

"The first assistant DA I worked with was very responsive and informative."
—32-year-old female

"Honestly, I can't think of anything positive that has come of it but for the fact that my attacker has had to deal with lawyers since the week he assaulted me, and that is a punishment I wouldn't wish on anyone. Also, restraining orders have been issued and renewed, so that is good." —28-year-old female

"My DA. [She] was awesome! She is a great lady, very professional."
—30-year-old female

"I wanted to press charges and did. Even though I felt it was a lost cause. I felt that I needed to do it for me and for the progression of this fight."
—25-year-old female

Providing Quality Services to Survivors with Physical Disabilities

"People think I am a wheelchair with a person attached rather than a PERSON in a wheelchair."
—55-year-old female (emphasis original)

It is estimated that more than 70% of women with a wide variety of disabilities (both physical and developmental) have been victims of sexual violence at some point in their lives (Stimpson & Best, 1991 as cited in Elman 2005). The majority of the violence is perpetrated by someone the victim knows. A large majority of the perpetrators are male caregivers, followed by male family members and only a small percentage are strangers (Sobsey & Doe, 1991 as cited in Elman, 2005).

Help Seeking Behavior

Although most people with disabilities live independently, there is still a reliance on others for care, and this makes it difficult to report those very people as abusers since it might trigger the end of a relationship and loss of essential care. Some abusers may be so controlling that those they victimize have no way to disclose the abuse to others. Furthermore, there are many obstacles for people with disabilities that make it difficult for them to access services. These can include the absence of accessible reporting devices (e.g. TTY's), assistance personnel (e.g. interpreters for the deaf), comfortable examination equipment, accessible transportation and building spaces.

The following quotes from a survivor highlights the frustration over not receiving quality care:

"Somehow law enforcement and hospitals think we have no reality as real people and that the last thing they want to do is deal with sexual issues in someone who has mobility limits."

"...Seems people go into a brain buzz when asked if they have ever dealt with disabled persons."

"The system is broken for disabled persons"

"Persons with physical disabilities are treated badly and not given any credibility. Even with materials brought nobody took it seriously. The only medical information I received and got was a bowel resectioning because of the beating I endured and the sexual issue was trivialized and not taken into account at all. I still have the DNA and nobody took it or took me seriously to this day. If the statute of limitations on rape is ever gotten rid of I have the DNA evidence to get this guy put in jail. But no report was ever taken and nothing was ever done to help."

Successful programs that provide services to survivors with disabilities are able to address the scope of the problem, adopt policies to ensure programs are accessible, facilitate an ongoing dialogue between victim service programs and disability programs, and use a community approach by including other key stakeholders in the development and ongoing service provision process.

Navigating law enforcement and the criminal justice system can also be very difficult.

Survivor Voices:

What was the worst thing about going to the District Attorney's office?

"the feeling that what I was doing was not going to make a difference and that no one believed me. I felt like just a number. I would not recommend to any victim that they go through the justice system."

—26-year-old female

"Embarrassment of telling my case to grand jury, but [my prosecutor] made me comfortable! She rocks!"

—30-year-old female

"It lasted forever. I had to keep reliving the situation over and over. The defendants went to the same college as I did and it was really hard to go through the process and have to see them all the time."

—25-year-old female

"Hard to get her when I needed questions [answered]." —53-year-old female

"When my case was transferred to another assistant DA, he did not follow up on the case and I had to call him to find out what the outcome was."

—32-year-old female

"Feeling like nobody believed me, feeling like I was responsible for the crime, feeling helpless and out of options."

—25-year-old female

"The apathy—insensitivity to victims... which resulted in more mental pain/anguish and hopelessness regarding help and safety." —36-year-old female

"...She [the prosecutor] listed four charges that would be brought against the attacker. I asked several times that he be forced to attend therapy sessions. She said this was a definite possibility. She seems to be doing everything in her power NOT to go to trial, because it would be a waste of her time. She offers the criminal the same GREAT deal every month, and every month he turns it down. At what point will we go to trial? She does not tell me what is happening at any point."

She has told me that I cannot attend court proceedings because I would be in violation of the restraining order, and she has now informed me that her office does not deal out sentences of therapy because they are an office of punishment, not a "holistic" office. She said it's either community service or jail. I told her I wanted him to go to jail then if that was the only option, and she thought that was very funny, laughed and said that "would not happen." Now the charges they are offering him are not even close to what we started with, they're not even sexual anymore. I mentioned that I wanted him to register as a sex offender, and she laughed and said that that would only happen when children are involved." (emphasis original)

—28-year-old female

"Re-telling the story...and being in the DA's office was tedious and intimidating..."

—24-year-old female



Survivors' Recommendations

Seventeen survivors gave recommendations to help make the criminal justice system better for other survivors.

1. Provide sensitivity training for prosecutors

Similar to recommendations for improving law enforcement, survivors recommended more training for prosecutors on interacting with survivors. Specifically, it was mentioned that prosecutors should receive sensitivity training for working with victims of sexual violence. Also, a recommendation was made for educational manuals about disabled persons and the Uniform Duties to Disabled Persons Act to be enforced.

"Get people who care about the rights of victims not defend their own people."

—36-year-old female

"...I think that entire office could use some sensitivity training."

—44-year-old female

2. Better communication

Many survivors felt that the criminal justice system would improve if there were better communication between the prosecutors and victims.

"Better communication, especially if the person who you are dealing with is transferred off the case."

—32-year-old female

"Just trying to reach her—she has a tight schedule."

—53-year-old female

3. Implement and connect with other support services

Several respondents stated that in order to make the criminal justice response better that it is important to implement support services or to connect with already existing support services, such as safe housing/shelter and to provide this information to survivors in a useful way.

"I think I was really lucky and worked with an ADA who was amazing. She really cared and motivated me to keep going with the case. She has since been promoted and works in the US Supreme Court now. It would be more helpful if service information was provided to a victim, maybe in a packet or something. In my experience I was in a daze and it was difficult to process all the info."

—25-year-old female

"Safe housing/shelter. Relocation assistance programs. Counseling services in public NYC schools. Publication in ads in popular newspapers and websites about organizations in all five boroughs. Employment training/education programs."

—36-year-old female

Chapter 6: Implications

Sexual assault is prevalent in our city. National surveys estimate that at least 17.6% of adult women and 3% of adult men have been raped (attempted and completed) during their lifetime (Tjaden & Thoennes, 2006). If these proportions are applied to NYC, approximately 1.3 million women and over 200,000 men have been raped at some point in their lives. In the last year alone in NYC, it is estimated that over 22,000 women and nearly 7,000 men were raped. These are numbers of staggering proportions. For those that have experienced rape, we know that very few will seek help. From July 2004 to June 2005, 1,339 adult survivors sought counseling services at NYC's rape crisis programs (NYS DOH, 2005). Furthermore, only 1,498 cases of rape were reported to the NYPD in 2006 (NYPD, 2006), representing less approximately 5% of the estimated rapes that are actually occurring.

Sexual violence has serious implications for individuals and society as a whole. This epidemic significantly and negatively impacts the physical and mental health of its victims both in the immediate aftermath and throughout the lifespan. In the Commonwealth Fund's 1998 Survey of Women's Health, women who experienced sexual violence by someone they knew were 2.8 times more likely to rate their health as fair or poor than women who had not experienced any violence (Plichta & Falik 2001). Furthermore, those who have experienced sexual violence by an intimate (partner, friend, relative, spouse) were 3.5 times more likely to report disabilities (self-assessment as having any condition that keeps her from participating fully in life activities) than those who have not experienced sexual violence (Plichta & Falik 2001).

While we know that few survivors seek care, for those who do the quality of care they receive and how they are treated is important for their recovery from the trauma of the assault. What is clear from this study is that while many survivors are receiving adequate care in a respectful manner, many are

not. One survivor who is treated poorly or not given proper care is one too many. As service providers, advocacy organizations, city agencies and committed individuals, we need to work together to ensure that NYC provides the best care for survivors of sexual violence.

Dialogue is the first step to ensuring that *all* sexual assault survivors in NYC are receiving quality care. The point is to not merely avoid negative feedback but to foster a climate of change within institutions and throughout New York City that supports, rather than revictimizes, survivors of sexual violence when they seek help.

Some important questions to consider:

- Since findings show that survivors are more likely to be satisfied with the care they receive at the hospital if it is a SAFE Center of Excellence, what infrastructure will ensure that *all* survivors are able to access a SAFE Center? How many SAFE programs are still needed in NYC? What is the best way to let the public know about these SAFE and SART programs?
- What infrastructure will ensure that *all* survivors who present at an emergency department in NYC have access to volunteer rape crisis advocates?
- What standards will ensure that survivors receive quality care and how can we ensure that these standards are, in fact, being implemented?
- How can we ensure that training of service providers, law enforcement and criminal justice responders is incorporated into the institutional structure? Since there is a high turnover in all of these service sectors, how can we ensure that everyone is on the same page regarding the expected standard of care?

- What needs to be in place to develop and implement cultural competency training in working with underserved populations, as well as removing specific barriers to services and improving services to these populations?
 - What specifically needs to be done to make sure that the issue of quality care is addressed for the following populations:
 - survivors with mental illness
 - male survivors
 - disabled survivors
 - LGBT survivors
 - What needs to happen so that all four sectors—hospital, rape crisis programs, police and DA's offices are working collaboratively and ensuring appropriate referrals and follow-up is taking place?
 - How can we limit the number of times a survivor has to tell the details of the assault?
 - How can we include survivors in all of our planning, trainings and implementation for program improvement across the sectors?
 - How can we ensure that 911 dispatchers are appropriately trained to handle sexual assault cases?
 - What is the best way to move forward on the survivor recommendations? (See Table 1 for summary of all recommendations)
 - How do we ensure that *all* survivors have access to the best quality care and response in NYC?
- Providing quality care for sexual assault survivors in NYC demands action. Talking openly about the strengths *and* weaknesses in service provision to survivors in NYC is necessary to create an atmosphere that is supportive and victim-centered.

Table 1: Overview of Survivor Recommendations

Hospitals	Rape Crisis Programs	Police	District Attorney's Offices
More training for service providers and responders	More training for service providers and responders	More training for police officers and responders	More training for prosecutors and responders
Provide Rape Crisis Advocates	Provide referrals for other services	Provide referrals for other services	Provide referrals for other services
Screen for sexual violence in the ED	Offer long-term counseling	Treat sexual assault as a serious crime	Improve communication with victims
Provide comprehensive treatment	More group therapy	Ensure privacy for survivors	
Decrease the wait time in the ED	Offer free services	Have more female officers available to handle sexual assault cases	
Have more specially trained clinicians			

Appendix A: Methodology

Overview

This study employed a cross-sectional, pilot-tested survey design to measure survivors' satisfaction with service providers and first responders after a sexual assault. The survey was open to adult (18 years and older) who experienced a sexual assault and sought services for that assault in NYC. The assault for which they sought services must have occurred when they were an adult.

There were two recruitment arms to this study: **1)** through rape crisis programs and **2)** a general online survey that was advertised widely across NYC through community-based organizations, newspaper ads, and support services for survivors. Survivors who were currently seeking services at one of the thirteen rape crisis programs that participated in this study were invited to take the survey. Survivors recruited through rape crisis programs were given an option of completing either a paper survey or the online version. Only 20% of this convenience sample completed a paper survey, the other 80% completed the online version. Due to the sampling method, participation rates could not be calculated.

The survey was made available in both Spanish and English. This study was approved by the Institutional Review Boards of eight organizations—St. Luke's-Roosevelt, Harlem Hospital, Safe Horizon, Long Island College Hospital, Mt. Sinai, St. Vincent's Catholic Medical Centers, Beth Israel Medical Center, and the NYC Gay and Lesbian Anti-Violence Project.

Sampling and Subject Selection

Table 2 details the distribution of the sample in this study. A total of 77 respondents filled out the survey; 12 of these did not meet the study criteria and were excluded from the study leaving a total sample size of 65 respondents. The most common reasons for exclusion from the study included either respondents under the age of 18 or respondents who were assaulted when they were under the age of 18. This study was limited to survivors ages 18 and over, and we see a much larger percentage of respondents in the 20–30 age range. However, all of the age ranges are represented in the study. Most of the respondents are female.

Hispanics are underrepresented in the study, despite the survey being available in Spanish and advertisements placed in Spanish speaking organizations and newspapers. Future research should be conducted to assess the satisfaction with services among this group. Asian and Pacific Islanders are also underrepresented in this study. The respondents in this study lived primarily in Brooklyn or Manhattan despite citywide advertising about the study. A concentrated effort should be given to recruiting participants from the Bronx, Queens and Staten Island in future studies.

Table 2: Sample Distribution —Total Sample: 65*

Gender	% of sample	Education Level	% of sample
Female	91	No School	—
Male	7	Grade School	—
Transgendered (FtM)	2	Some High School	5
		High School Diploma	14
		Two-year College	24
		Undergraduate	40
		Graduate Degree	17
Age		Borough of Residence	
18–20	5	Bronx	5
20–30	48	Brooklyn	40
30–40	23	Manhattan	44
40–50	15	Queens	2
50–60	9	Staten Island	2
		Outside NYC	7
Race/Ethnicity			
African American/Black	25		
Asian or Pacific Islander	5		
Hispanic	12		
Native American/Alaskan Native	3		
White	55		
Sexual Orientation			
Heterosexual/Straight	84		
Gay	5		
Lesbian	—		
Bisexual	9		
Undecided	2		

* Missing data excluded

— No one in sample

Formative Research

To inform the design of the survey, key stakeholder interviews were held with service providers regarding the best way to sample the survivor population and ways to reach special populations. In the fall of 2003, interviews were conducted with 18 key stakeholders representing each of the four sectors, and also including other organizations that have conducted survivor satisfaction surveys. The interviews focused on four major themes:

1. Defining Satisfaction

To understand the concept(s) of satisfaction and access as they are understood by service providers. To

this end, service providers were asked to describe the details of the services available to rape survivors. Their responses helped us assure that our survey will indeed ask survivors to provide feedback on the entire spectrum of services available to them (recognizing that some survivors may encounter a larger array of services than others).

2. Understanding the context or environment of providing care for survivors.

Key stakeholders were asked about the feasibility and appropriateness of fielding the survey in various locations and at different times.

3. Order of Events

Speaking with both service providers/stakeholders and survivors helped us understand the way that events unfold after a person reports that (s) he was sexually assaulted. The service providers were very helpful in outlining the work they each do and in explaining the spectrum of agencies that offer sexual assault survivor services.

4. Special Circumstances

The interviews were useful to anticipate special circumstances. For example, we spoke with service providers about how to reach out to marginalized populations—such as the elderly, men, gay men, lesbians, transgendered persons, and undocumented immigrants. The service providers offered useful ideas on how to reach out to these groups when distributing the survey.

A focus group was conducted with survivors in February 2004 to review the survey and to elicit ideas for survey changes. Participants were recruited by flyers placed at local rape crisis programs and through the Alliance's website. Survivors examined the survey question-by-question and suggested changes; these changes are reflected in the survey that was utilized for this study. Focus group participants helped elucidate the path survivors take when navigating the system.

The survey was conducted at rape crisis programs and as an online survey through the Alliance's website. These locations were decided based on the following factors:

- Stakeholders and survivors indicated that the ED is not the ideal place to conduct a satisfaction survey that looks at a range of services, as the ED is usually the first point of contact with this system of services. Furthermore, they cautioned that administering a survey in this circumstance might be too traumatic for survivors.
- Stakeholders highlighted that the organizational capacity for giving a survey to survivors upon contact with the NYPD was also not realistic. Furthermore, the counseling component would not be present if the survey brought up painful memories.

- Many stakeholders felt that rape crisis programs present a good location to field the survey. The location provides counseling opportunities if the survey brings up any issues that the survivor may want to talk about.
- The survey was also available on the Alliance's website and through print and radio media. This was done to recruit respondents who were not currently involved with a rape crisis program but had sought help from one of the other sectors in NYC.

Spanish Translation

Since an English language pilot that focused on the survey format and wording was already conducted, it was determined that the Spanish pilot should focus on the correct translation of the survey. The Principal Investigator organized a conference call between our Spanish Translator and several Spanish-speaking rape crisis counselors across the city. The items discussed included appropriate translation of key words (such as victim advocate, sexual assault) and making sure the translation was appropriate for all key dialects of Spanish.

The Spanish-speaking rape crisis counselors represented the Puerto Rican, Dominican and Chilean Spanish but were also knowledgeable about other dialects of Spanish spoken since they serve clients from almost every Spanish speaking country. The rape crisis counselors and the translator went question by question in the survey and came to a consensus on all the translations.

Limitations in Study Design

Due to the difficulties in sampling survivors of sexual violence, a non-random convenience sampling methodology was utilized. The consequence of using a nonprobability sampling strategy is that an unknown portion of the population is excluded. Because some members of the population (adult survivors in NYC that have accessed services for the assault) have no chance of being sampled, the extent to which this sample represents the entire

population cannot be known. Despite these limitations, the study provides tremendous insight into the experiences of sexual assault survivors as they access services in NYC and will be useful for program improvement.

Validity

Internal Validity

A study is valid if its questions actually measure what they claim to, and if there are no logical errors in drawing conclusions from the data. “Threats to internal validity” means that variables other than those being studied may impact the satisfaction of services. Several threats to internal validity were examined and addressed.

One threat to internal validity is the ‘*Hawthorne Effect*,’ which asks if the expectation or actions of the investigator contaminate the outcomes of the study? Does having a counselor administer the consent form or taking the survey in the counseling office impact the respondents’ responses to being satisfied with that service provider? This threat has been minimized by not having the counselor administer the survey (only giving the consent form) and by assuring the respondent that no one will be able to link the survey back to him or her.

A second threat to internal validity that was addressed in this study is selection bias. This is a concern; the respondents who actively seek counseling services may differ significantly from survivors who do not access these services. Plus, those who responded to the survey may differ from survivors who did not. An attempt has been made to minimize this bias by providing the web-based survey.

Another form of selection bias may occur due to the higher literacy level needed to fill out the survey. Efforts have been made to lower the literacy level of the survey including using both the Frye Formula and the SMOG test. At the beginning of survey development, both formulas revealed that the survey was college level reading. After several changes and rewording, explaining words that may be dif-

ficult to understand and also shortening sentences, the reading level is currently at 9th grade level. Due to the language needed to cover the satisfaction with services and the mode of data collection (web-based), this survey will exclude both survivors with very low literacy levels but also homeless survivors or survivors with a low socio-economic status (due to the computer use) unless they are currently in counseling services. Future studies are needed in which one-on-one interviews or an Audio Computer Assisted Self-Interviewing (ACASI) system is used. Unfortunately, this is a recognized bias in this study.

Closely tied with selection bias is the *maturation bias* meaning it is possible that the survivors survey in community-based and counseling programs differ in maturation or the passage of time since their assault than survivors who only access hospital or law enforcement services. We are uncertain the effects this will have on satisfaction levels.

External Validity

In addition to internal validity, studies should also be concerned about external validity which is concerned with any possible biases in the process of generalizing conclusions from a sample to a population, to other subject populations, to other settings, and/or to other time periods. The population for this study was survivors who sought services in NYC for the assault. The largest weaknesses in this study occur with external validity, primarily due to the non-random sampling technique and the small sample sizes. Due to these limitations, results from this study are not generalizable to the survivor population of New York City.

Despite considerable threats to external validity, efforts were made to minimize the effect of these biases on study results. An attempt was made to minimize this bias by ensuring that participating programs ask *all* of their clients if they would be interested in participating.

The training of service providers also helped minimize external validity by ensuring that all survivors are approached in a similar manner.

Due to the nature of the satisfaction survey, it may be that survivors who were very dissatisfied with the care they received were more likely to fill out the survey than survivors who were in the middle of the spectrum. Study results do show that survivors were more likely to fall at either end of the spectrum (very dissatisfied or very satisfied). While this is an important limitation, it is useful to understand dissatisfaction for program improvement purposes.

The web-based survey also presents a threat to external validity since there is no control over the sample distribution. An attempt was made to minimize this bias by ensuring that outreach for the web-based survey was wide-reaching and covered all types of communities.

Since the sampling design was not probabilistic, external validity was not going to be strong; nonetheless, our sampling design was intended to reach as many survivors who sought services as possible.

Construct Validity

Like external validity, construct validity is related to generalizing. But, where external validity involves generalizing from the study context to other people, places or times, construct validity involves generalizing from the measures or questions to the *concept* of the measures or questions. Construct validity may be thought of as a “labeling” issue. When we measure “satisfaction” is that what we are really measuring? Any threats to construct validity have been minimized by ensuring that the survey instrument was “focus-grouped” with survivors of sexual assault and through a careful examination of the literature and discussions with key stakeholders.

Satisfaction, though an ambiguous construct, is generally accepted and widely used.

Web-based Survey

The web-based survey component of the survivor survey is an exciting avenue for the Alliance to take in this research project. Web-based surveys hold great potential for surveying survivors who are not present in counseling type settings. Web-based surveys also show potential for surveying on sensitive topics. The web-based survey was open to all participants in the study and was the only method of survey implementation to reach the general NYC population. The Web Manager worked closely with the Principal Investigator to develop the web-based survey which was identical to the paper-based survey and also included the appropriate information to consent to participate in the study.

Web-based Survey Design

Several design items were developed and deemed as important for the web-based survey, these items include:

- The ability to support multiple platforms and browsers
- The ability to prevent multiple submissions (i.e. the inclusion of a time stamp)
- Providing the feedback ‘thank you’ upon completion of the survey
- The ability to export the data directly into a database (excel)
- Sequential screens to avoid download time
- Links available at the beginning and end of the survey to a list of support service information
- Web-based specific instructions (how to erase a check mark etc.)
- Introductory page (similar to approach script used by counselors)

It is important to protect the respondents' privacy and confidentiality for both the paper and web-based surveys. Methods that helped ensure the privacy and confidentiality for the web-based survey included:

- Using temporary cookies
- Certifying privacy through a 3rd party
- Using hypertext links for long disclosures
- Explanation in the introduction about the confidentiality of the survey (conditions of release, use, retention and disposal of personal data and sampling procedures)
- Collecting data through web pages versus e-mail (more secure)

The web-based survey design was piloted with computers that had different processing powers, internet service providers, internet access, operating systems and browsers to ensure that the web-based design would work consistently, given the varying types of computers systems and connection speeds. The pilot also checked the web-based design for ease in filling out the survey (large enough text boxes, skip responses, checking and unchecking answers, and coding).

Analysis

All quantitative data was analyzed using the Statistical Program for the Social Sciences (SPSS) 11.5 for Windows. Frequencies were calculated and presented for all the variables in the study. Independent sample t-tests were used to determine statistical significance for difference between means and are reported at the .05 confidence level, unless otherwise indicated.

The narrative data was obtained from several open-ended questions on the surveys, specifically for each service section the following questions were asked: **1)** was there anything that prevented you from going to [service sector, such as hospital, rape crisis program, police or District Attorney's office], **2)** what was the best thing about going to [service sector], **3)** what was the worst thing about going to [service sector], and **4)** what recommendation do you have to improve these services for other survivors?

The analysis used emergent categories to code the data using cross-case analysis, rather than using preconceived categories. After the first level coding, the data was pattern coded as a way of grouping those summaries into a smaller number of themes or constructs to examine the patterns, reoccurrences or "repeatable regularities" (Miles & Huberman 1994). This was done to help us better understand what prevents survivors from accessing services and what should change to improve services. Several outlying experiences were identified in the study: these included survivors who had very negative experiences across all the services they encountered. These narratives are presented in each chapter and are important for confirming the conclusion that the standard of care is low for certain populations across all sectors.

Code-recode reliability was conducted by coding on one day and then recoding the data three days later and checking the reliability which was high (over 90%). The qualitative and quantitative analysis as presented in this report was also reviewed by the Alliance's Research Advisory Committee.

Appendix B: Survey Instrument

* This survey is copyrighted. Please do not replicate the survey in whole or part without prior permission from the New York City Alliance Against Sexual Assault (contact research@nycagainstrape.org)

Satisfaction with Services in New York City

This survey is for adult survivors of sexual assault who have gone to services in New York City for the assault (hospital, counseling, police or the District Attorney's office).

This survey will help the New York City Alliance Against Sexual Assault improve services for survivors in New York City.

The information you provide is completely anonymous and no one will be able to link this survey back to you. It is important that you answer the questions to the best of your ability. You may skip any questions. Your participation is voluntary and you can choose to stop filling out the survey at any time. After each question, please mark the box that best matches your answer or opinion.

Please answer the questions about the **most recent** sexual assault.

1. When did the most recent sexual assault take place?
Year: _____
2. Where did the most recent sexual assault take place?
☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens
☐ Staten Island ☐ Outside New York City
3. How old were you when this assault happened?
Age: _____
4. Had you ever been sexually assaulted before this time? ☐ Yes ☐ No
5. What was the sex/gender of the person(s) who assaulted you?
☐ Man ☐ Woman ☐ Transgendered
6. Was the person who assaulted you a stranger?
☐ Yes ☐ No
If no, what was his/her relationship to you?
☐ person of authority (boss, teacher, commanding officer etc.) ☐ friend ☐ parent ☐ other relative
☐ dating partner ☐ husband ☐ wife
☐ someone I had seen before but was not friends with
☐ other (please specify _____)
7. Which of the following people/places did you contact first after the sexual assault?
☐ security/police
☐ rape crisis program/victim assistance program
☐ hospital ☐ prosecutor/District Attorney
☐ hotline ☐ called 911
☐ private counselor (not at a rape crisis program)
☐ church/religious organization
☐ other (please specify _____)
8. This place is in... ☐ Bronx ☐ Brooklyn ☐ Manhattan
☐ Queens ☐ Staten Island ☐ Outside New York City
☐ I don't know
9. How long after the assault did you contact this place?
☐ Within 1 day ☐ within 3 days ☐ within a week
☐ within 1 month ☐ within 6 months ☐ within 1 year
☐ more than 1 year later
10. This organization advised me to contact another place for more services.
☐ Yes ☐ No
11. Please check all the people/places you contacted after the most recent sexual assault:
☐ security/police ☐ rape crisis program/victim assistance program ☐ hospital
☐ prosecutor/District Attorney ☐ hotline ☐ called 911
☐ private counselor (not at a rape crisis program)
☐ church/religious organization
☐ other (please specify _____)
12. In total, how many people interviewed you about your most recent sexual assault? (including nurses, doctors, police, counselors, District Attorney's and others) 'Interview' means that these people asked you about the details of the assault so that they could help you, but not including family and friends.
_____ people

Section 1: Hospital Services

- 1.1. Did you go to a hospital after the most recent sexual assault?
☐ Yes (If yes, go to Question 1.3) ☐ No
- If no, was health insurance one reason why you did not go to the hospital?
☐ Yes ☐ No
- 1.2. Was there anything that prevented you from going to the hospital? Please explain. **(now go to Section 2)**
- 1.3. What was the name of the hospital?
Hospital (ex.: St. Maria's Hospital) _____
_____)
- 1.4. What year did you visit the hospital?
Year: _____)
- 1.5. Sometimes survivors have a counselor who helps guide them through the visit at the hospital. This counselor is called a **victim advocate** (also known as a rape crisis advocate or rape crisis counselor) and is not part of the hospital staff. Did you have a **victim advocate** at the hospital?
☐ Yes ☐ No (If "no", go to question 1.11)

If yes, please answer the following questions.

Victim Advocate:

- 1.6. The advocate explained the medical exam to me.
☐ Yes ☐ No
- 1.7. The advocate told me about reporting to the police.
☐ Yes ☐ No
- 1.8. The advocate gave me information about counseling.
☐ Yes ☐ No
- 1.9. The advocate gave me the support I needed during the hospital visit.
☐ Yes ☐ No
- 1.10. Overall, how satisfied were you with the advocate?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied

Other Hospital Staff:

Please answer yes or no for the following questions.

- 1.11. I waited a long time to see a doctor or nurse.
☐ Yes ☐ No
- 1.12. My doctor/nurse gave me information about sexual transmitted diseases (STDs) including HIV.
☐ Yes ☐ No
- 1.13. My doctor/nurse gave me information about emergency contraception to prevent pregnancy(also known as the 'morning after pill').
☐ Yes ☐ No ☐ Does not apply
- 1.14. My doctor/nurse gave me information about reporting to the police.
☐ Yes ☐ No
- 1.15. My doctor/nurse gave me information about medicine to prevent HIV.
☐ Yes ☐ No ☐ Does not apply
- 1.16. My doctor/nurse gave me information about photographing my injuries.
☐ Yes ☐ No ☐ Does not apply
- 1.17. My doctor/nurse told me who would see the photos.
☐ Yes ☐ No ☐ No photos were taken
- 1.18. Sometimes clothes are given to a survivor when they are at the hospital. Did you receive any clothes at the hospital?
☐ Yes ☐ No ☐ Does not apply
- 1.19. My doctor/nurse gave me information about going to a rape crisis center, counseling or support group.
☐ Yes ☐ No
- 1.20. My doctor/nurse made a follow-up medical appointment for me.
☐ Yes ☐ No ☐ Does not apply
- 1.21. My doctor/nurse asked if I had a safe place to go after leaving the hospital.
☐ Yes ☐ No
- 1.22. At any point, did you feel treated poorly at this hospital?
☐ Yes ☐ No **(If 'no' go to Question 1.23)**

If “Yes,” please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

- | | |
|---|--|
| My race
<input type="checkbox"/> Yes <input type="checkbox"/> No | My difficulty speaking English
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My age
<input type="checkbox"/> Yes <input type="checkbox"/> No | My profession
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My gender/sex
<input type="checkbox"/> Yes <input type="checkbox"/> No | My drug use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My disability
<input type="checkbox"/> Yes <input type="checkbox"/> No | My alcohol use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My religion
<input type="checkbox"/> Yes <input type="checkbox"/> No | The hospital staff didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My sexual orientation
<input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other (please specify)
_____ |
| My immigration status
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Please check the answer that best describes your experience.

- 1.23. My doctor/nurse tried to make me comfortable during the physical exam.
☐ strongly agree ☐ agree ☐ disagree
☐ strongly disagree ☐ does not apply
- 1.24. My doctor/nurse explained what was going to happen every step of the exam.
☐ strongly agree ☐ agree ☐ disagree
☐ strongly disagree ☐ does not apply
- 1.25. My doctor/nurse explained the side effects of my HIV medication in a way I could understand.
☐ strongly agree ☐ agree ☐ disagree
☐ strongly disagree ☐ does not apply
- 1.26. Overall, how satisfied are you with the care you received at the hospital after the most recent sexual assault?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 1.27. The best thing about seeking medical care was:

1.28. The worst thing about seeking medical care was:

1.29. What would you add or change to make this hospital a better place for yourself and other survivors?

Section 2: Rape Crisis and Victim Assistance Programs

If you went to more than one program, please answer for the most recent place you visited.

- 2.1. Did you go to any rape crisis or victim's assistance program after the last sexual assault?
☐ Yes **(If yes, go to question 2.3)** ☐ No
- 2.2. If no, was there anything that prevented you from going to a rape crisis or victim's assistance program? Please explain.

(now go to section 3)

- 2.3. What was the name of the program you visited?
Program Name: _____
- 2.4. What year did you first visit this program?
Year: _____

Please answer if you agree or disagree with the following statements:

- 2.5. I felt I could trust my counselor.
☐ strongly agree ☐ agree ☐ disagree
☐ strongly disagree
- 2.6. I felt my counselor knew how to help me.
☐ strongly agree ☐ agree ☐ disagree
☐ strongly disagree

Please answer yes or no for the following questions:

- 2.7. My counselor gave me information about what to expect from reporting to the police.
☐ Yes ☐ No ☐ Does not apply
- 2.8. My counselor gave me information about what to expect from the District Attorney.
☐ Yes ☐ No ☐ Does not apply
- 2.9. My counselor spoke to the police for me.
☐ Yes ☐ No ☐ I did not want them to speak to the police ☐ Does not apply

- 2.10. My counselor spoke to the District Attorney for me.
☐ Yes ☐ No ☐ I did not want them to speak to the District Attorney ☐ Does not apply
- 2.11. Did you fill out a form to get money back for what you spent on the hospital visit? This form is also called a crime victims' compensation form.
☐ Yes ☐ No ☐ Does not apply (I didn't go to hospital)
- 2.12. If yes, did your counselor help you fill out this form?
☐ Yes ☐ No
- 2.13. I was satisfied with the advice given to me on how to speak with my partner about the assault. By partner, we mean your boyfriend, girlfriend, husband or wife.
☐ Yes ☐ No ☐ Was not given any advice
☐ Does not apply (I did not have a partner at the time)
- 2.14. Overall, I feel better as a result of my counseling experience.
☐ Yes ☐ No
- 2.15. I felt comfortable speaking with the counselor about my experiences.
☐ all of the time ☐ most times ☐ sometimes
☐ rarely ☐ never
- 2.16. At any point, did you feel treated poorly at this rape crisis or victim assistance program?
☐ Yes ☐ No (If 'no' go to Question 2.17)

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

- | | |
|---|--|
| My race
<input type="checkbox"/> Yes <input type="checkbox"/> No | My difficulty speaking English
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My age
<input type="checkbox"/> Yes <input type="checkbox"/> No | My profession
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My gender/sex
<input type="checkbox"/> Yes <input type="checkbox"/> No | My drug use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My disability
<input type="checkbox"/> Yes <input type="checkbox"/> No | My alcohol use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My religion
<input type="checkbox"/> Yes <input type="checkbox"/> No | The counselors staff didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My sexual orientation
<input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other (please specify) _____ |
| My immigration status
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Please answer how satisfied you were with the following services.

- 2.17. How satisfied were you with the emotional support provided to you by your counselor?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 2.18. Overall, how satisfied were you with the rape crisis or victim assistance program?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 2.19. The best thing about going to a rape crisis center or victim assistance program was:
- 2.20. The worst thing about going to a rape crisis center or victim assistance program was:
- 2.21. What would you add or change to make this program a better place for yourself and other survivors?

Section 3: Police

- 3.1. Did you ever go to the police after the last sexual assault?
☐ Yes (if yes, go to question 3.3) ☐ No
- 3.2. If no, was there anything that prevented you from going to the police? Please explain. (now go to section 4)
- 3.3. Who contacted the police?
☐ I did ☐ family ☐ friend ☐ the hospital staff
☐ my husband/wife/boyfriend/girlfriend
☐ stranger ☐ other (specify _____)
- 3.4. How were the police contacted?
☐ 911 phone call ☐ at the hospital
☐ at a police station
☐ Other (specify) _____

- 3.5. Have you ever had a bad experience with the police before this most recent sexual assault?
The officers in uniform didn't believe me
☐ Yes ☐ No
- 3.6. How long after the most recent sexual assault were the police contacted?
☐ Within 1 day ☐ 2-14 days after ☐ 2-4 weeks later
☐ 1-3 months ☐ more than 3 months later
- 3.7. What time of the day were the police contacted?
☐ Between 8am and midnight
☐ Between midnight and 7:59am ☐ I don't know
- 3.8. How many police officers did you speak with about the most recent sexual assault?
_____ officers
- 3.9. Did any police officer give you information about going to a rape crisis center, counseling or support group?
☐ Yes ☐ No ☐ Does not apply
- 3.10. At any point, did you feel treated poorly by the police?
☐ Yes ☐ No (If 'no' go to Question 3.11)

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

- | | |
|--|--|
| My race
<input type="checkbox"/> Yes <input type="checkbox"/> No | My profession
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My age
<input type="checkbox"/> Yes <input type="checkbox"/> No | My drug use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My gender/sex
<input type="checkbox"/> Yes <input type="checkbox"/> No | My alcohol use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My disability
<input type="checkbox"/> Yes <input type="checkbox"/> No | The officers in uniform didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My religion
<input type="checkbox"/> Yes <input type="checkbox"/> No | The non-uniformed officers didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My sexual orientation
<input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other (please specify)
_____ |
| My immigration status
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| My difficulty speaking English
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

The following questions are about the type of police officer(s) you spoke with. Some of the officers wear a uniform (patrol officers) and others are not in a uniform (detectives).

Officers in Uniform

- 3.11. After the most recent sexual assault, did you speak with an officer in uniform?
☐ Yes ☐ No (If 'no' go to question 3.15)
- 3.12. How satisfied were you with the way the officer in uniform treated you?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 3.13. How satisfied were you with the explanation given to you by the officer in uniform about why certain questions were asked?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 3.14. Did the officer in uniform make efforts to address your safety concerns?
☐ Yes ☐ No ☐ I did not have any safety concerns

Non-Uniformed Officers

- 3.15. Did you speak with a police officer not in uniform (in plain clothes including detectives)?
☐ Yes ☐ No (If 'no' go to question 3.21)
- 3.16. How satisfied were you with the way you were treated by the non-uniformed officers assigned to your case?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 3.17. How satisfied were you with the explanation given to you by the non-uniformed officer about why certain questions were asked?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 3.18. Did the non-uniformed officer make efforts to address your safety concerns?
☐ Yes ☐ No ☐ I did not have any safety concerns
- 3.19. Did the non-uniformed officer give you information about what to expect during the investigation?
☐ Yes ☐ No ☐ Does not apply
- 3.20. Did the non-uniformed officer make efforts to keep you informed as the investigation continued?
☐ Yes ☐ No ☐ Does not apply

Other Police Questions:

- 3.21. The best thing about going to the police was:
- 3.22. The worst thing about going to the police was:
- 3.23. What would you add or change about the police to make the services better for yourself and other survivors?

Section 4: District Attorney's Office

- 4.1. Did you seek services from a District Attorney after the most recent sexual assault?
☐ Yes (If yes, go to question 4.3) ☐ No
- 4.2. If no, was there anything that prevented you from going to a District Attorney? Please explain. **(now go to section 5)**
- 4.3. I went to the District Attorney's office in...
☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens
☐ Staten Island ☐ Outside NYC
- 4.4. What year did you go to the District Attorney's office?
Year: _____
- 4.5. How long after the most recent sexual assault did you go the District Attorney's office?
☐ within a week ☐ within 1 month
☐ within 6 months ☐ within 1 year
☐ more than 1 year later
- 4.6. How satisfied were you with the way you were treated during the first interview?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied

Please answer yes or no for the following:

- 4.7. Information was given to me about the possible outcomes of my case.
☐ Yes ☐ No ☐ Does not apply
- 4.8. My lawyer/prosecutor made efforts to limit court delays.
☐ Yes ☐ No ☐ Does not apply
- 4.9. My lawyer/prosecutor gave me information about plea agreements.
☐ Yes ☐ No ☐ Does not apply
- 4.10. My lawyer/prosecutor gave me information about whether my attacker(s) had been arrested?
☐ Yes ☐ No ☐ Does not apply
- 4.11. Did you receive counseling at the District Attorney's office?
☐ Yes ☐ No **(If no, go to question 4.17)**
- 4.12. My counselor at the District Attorney's office gave me information about what to expect from the prosecution process.
☐ Yes ☐ No
- 4.13. My counselor at the District Attorney's office spoke to the District Attorney for me.
☐ Yes ☐ No
- 4.14. My counselor at the District Attorney's office helped me fill out a form to get money back for what I spent on the hospital visit. Also called a crime victims' compensation form.
☐ Yes ☐ No ☐ I did not go to the hospital
- 4.15. How satisfied were you with the emotional support provided to you by the counselor at the District Attorney's office?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 4.16. Overall, how satisfied were you with the counseling program at the District Attorney's office?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied
- 4.17. Did you testify in court?
☐ Yes ☐ No **(If no, go to question 4.20)**
- 4.18. If yes, how satisfied were you with the information given to you about testifying in court?
☐ very satisfied ☐ satisfied ☐ dissatisfied
☐ very dissatisfied ☐ does not apply

4.19. If yes, did you feel well-prepared to testify?

☐ Yes ☐ No

4.20. Did you want to press charges but after going to the District Attorney's office felt that you could not?

☐ Yes ☐ No (if no, go to question 4.22)

4.21. If yes, why did you feel this way?

4.22. At any point, did you feel treated poorly at District Attorney's office?

☐ Yes ☐ No (If 'no' go to Question 4.23)

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

My race

☐ Yes ☐ No

My age

☐ Yes ☐ No

My gender/sex

☐ Yes ☐ No

My disability

☐ Yes ☐ No

My religion

☐ Yes ☐ No

My sexual orientation

☐ Yes ☐ No

My immigration status

☐ Yes ☐ No

My difficulty speaking English

☐ Yes ☐ No

My profession

☐ Yes ☐ No

My drug use

☐ Yes ☐ No

My alcohol use

☐ Yes ☐ No

The District Attorney didn't believe me

☐ Yes ☐ No

The counselors didn't believe me

☐ Yes ☐ No

☐ other (please specify)

4.23. Overall, how satisfied were you with the services you got from the District Attorney's office?

☐ very satisfied ☐ satisfied ☐ dissatisfied

☐ very dissatisfied

4.24. What was the timeline for prosecuting your case?

Amount of time spent: _____

☐ Does not apply

4.25. What was the final outcome of the case?

☐ conviction ☐ acquittal ☐ dropped/dismissed

☐ plea agreement ☐ case sealed ☐ still pending

☐ other (specify _____)

4.26. The best thing about going to the prosecutor/District Attorney was:

4.27. The worst thing about going to the prosecutor/District Attorney was:

4.28. What would you add or change about the prosecutor/District Attorneys office to make the services better for yourself and other survivors?

Section 5: Information about you

5.1. What is your year of birth?

Year (example: 1973) _____

5.2. My sex/gender is:

☐ Female ☐ Male ☐ Transgendered (MTF)

☐ Transgendered (FTM)

5.3. My sexual orientation is:

☐ straight/heterosexual ☐ gay ☐ lesbian

☐ bisexual ☐ not sure

5.4. My racial/ethnic background is... (check all that apply)

☐ African American/Black ☐ Hispanic/Latino

☐ Asian/Pacific Islander ☐ American/Alaskan Native

☐ White ☐ Other (specify _____)

5.5. My highest level of education is:

☐ no school ☐ grade school ☐ some high school

☐ high school diploma ☐ two-year college

☐ undergraduate degree ☐ graduate degree or more

5.6. I live in:

☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens

☐ Staten Island ☐ Outside NYC

Thank you for taking time to complete this survey.

“When a girl comes in with broken ribs and says the injury happened while she was on a blind date, and then she starts sobbing, you might take her aside and ask her if she was sexually assaulted. I went to three different hospitals and not one person asked me that...”

—37-year-old female

References

- Agar, K. & Read, J. (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing*, 11, 70-79.
- Arata, C.M. (2000). From child victim to adult victim: a model for predicting sexual revictimization. *Child Maltreatment*, 5, 28-38.
- Barrier Free Justice. *For women from the disabled or deaf community who are victims of domestic violence and/or sexual assault*. Retrieved May 2006 from http://www.brooklynda.org/barrier_free_justice/barrier_free_justice.htm.
- Brooklyn District Attorney's Office. (2007). *The Brooklyn S.T.A.R. Project*. Retrieved 2007 from http://www.brooklynda.org/star/star_project.htm
- Campbell, R. (2005). What really happened? A validation study of rape survivors' help-seeking experiences with legal and medical systems. *Violence and Victims*, 20, 55-68.
- Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women*, 12, 30-45.
- Catalano, S. M. (2005). *Criminal Victimization 2004: National Crime Victimization Survey*. (NCJ 210674). Bureau of Justice Statistics.
- Clark, C., Becker, M., Giard, J., Mazelis, R., Savage, A., & Vogel, W. (2005). The role of coercion in the treatment of women with co-occurring disorders and histories of abuse. *Journal of Behavioral Health Services & Research*, 32, 167-181.
- Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence & Abuse*, 6, 103-129.
- Coyle, J. (1999). Understanding dissatisfied users: Developing a framework for comprehending criticisms of health care work. *Journal of Advanced Nursing*, 30, 723-731.
- Desai, S., Arias, I., Thompson, M.P. & Basile, K.C. (2002). Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men. *Violence and Victims*, 6, 639-653.
- Elman, R. A. (2005). Confronting the sexual abuse of women with disabilities.
- Fergusson, D.M., Horwood, L.J., Lynskey, M.T. (1997). Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse & Neglect*, 21, 789-803.
- Finkelhor, D. & Browne, A. (1985). The traumatic impact of child abuse: a conceptualization. *American Journal of Orthopsychiatry*, 55, 530-541.
- Fischer, B., Cullen, F. & Turner, M. (2000). The sexual victimization of college women. Washington, D.C. : U.S. Department of Justice, National Institute of Justice and Bureau of Justice Statistics.
- Gidycz, C. A., Coble, C. N., Latham, L., & Layman, M. J. (1993). Sexual assault experience in adulthood and prior victimization experiences. *Psychology of Women Quarterly*, 17, 151-168.
- Girshick, L. B. (2002). *Woman-to-woman sexual violence*. Boston: Northeastern University Press.
- Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., Osher, F. C., Butterfield, M. I., & Swanson, J. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress*, 14, 615-632.
- Harris, M. & Landis, C.L. (Eds.). (1997). *Sexual abuse in the lives of women diagnosed with serious mental illness*. Amsterdam: Overseas Publishers Association.

- Humphrey, J.A. & White, J.A. (2000). Women's vulnerability to sexual assault from adolescence to adulthood. *Journal of Adolescent Health*, 27, 419-424.
- Isely, P. J. & Gehrenbeck-Shim, D. (1997). Sexual assault of men in the community. *Journal of Community Psychology*, 25, 159-166.
- Jankowski, M., Leitenberg, H., Henning, K. & Raffey, P. (2002). Parental caring as a possible buffer against sexual revictimization in young adult survivors of child sexual abuse. *Journal of Traumatic Stress*, 15, 235-244.
- Jennings, A. (1994). Commentary: On being invisible in the mental health system. *Journal of Mental Health Administration*, 21, 374-387.
- Kessler, B.L. & Bieschke, K.J. (1999). A retrospective analysis of shame, dissociation and adult revictimization in survivors of childhood sexual abuse. *Journal of Counseling Psychology*, 46, 335-341.
- Kilpatrick, D. G., Aceiarno, R., Resnick, H. S., Saunders, B. E., & Best, C. L. (1997). A 2-year longitudinal analysis of the relationship between violent assault and substance abuse in women. *Journal of Consulting and Clinical Psychology*, 65, 834-847.
- King, M. & Woollett, E. (1997). Sexually assaulted males: 115 men consulting a counseling service. *Archives of Sexual Behavior*, 26, 579-588.
- Lipscomb, G. H., Muram, D., Speck, P. M., & Mercer, B. M. (1992). Male victims of sexual assault. *Journal of the American Medical Association*, 267, 3064-3066.
- Mendel, M. P. (1995). *The male survivor: The impact of sexual abuse*. London: Sage Publications, Inc.
- Messman-Moore, T.L. & Long, P.J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women: an empirical review and theoretical reformulation. *Clinical Psychology Review*, 23, 537-571.
- Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: An Expanded Source Book*. Second Edition. Thousand Oakes: Sage Publications, Inc.
- Moeller, T.P., Bachman, G.A. & Moeller, J.R. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: long-term health consequences of women, *Child Abuse & Neglect*, 17, 623-640.
- Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., Auciello, P., & Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66, 493-499.
- New York City Mayor's Office to Combat Domestic Violence (OCDV). *Initiatives: Criminal Justice*. Retrieved 2006, from <http://home2.nyc.gov/html/ocdv/html/initiatives/justice.shtml>
- New York County District Attorney's Office (NYDA), *Trial Division-Legal Units*, Sex Crimes Unit. Retrieved 2006, from http://www.manhattanda.org/office_overview/trial/legal/sex_crime.htm
- New York City Police Department (NYPD). (2006). *CompStat: Report covering the week of 03/05/2007 to 03/11/2007; Historical perspective*. Retrieved 2007, from <http://www.nyc.gov/html/nypd/pdf/chfdept/cscity.pdf>
- New York State Department of Health. (2004). *Protocol for the acute care of the adult patient reporting sexual assault*. Retrieved May 2006 from http://www.health.state.ny.us/professionals/protocols_and_guidelines/sexual_assault/index.htm
- New York State Department of Health. (2005). *New York City Statistics: 2005*. Retrieved May 2006 from http://www.nycagainstrape.org/research_fact-sheet_117.html
- New York State Department of Health. (2006). *SAFE Centers*. Retrieved May 2006, from http://www.hospitals.nyhealth.gov/browse_search.php?form=CENTER&rt=6.
- New York State Public Health Law. (2002). Treatment of Sexual Offense Victims and Maintenance of Evidence in a Sexual Offense, §2805-l.

- Plichta, S. B. & Falik, M. (2001). Prevalence of violence and its implications for women's health. *Women's Health Issues*, 11, 244-258.
- Police Academy. (2006). *The Recruit Training Section Student Guide*. New York: Police Academy.
- Project Shield. (2004). *Project Shield: Kings County District Attorney's Office*. [Brochure].
- Randall, M. & Haskeell L. (1995). Sexual violence in Women's Lives. *Violence Against Women*, 1, 6-13.
- Reisig, M. D. & Parks, R. B. (2002). *Satisfaction with police – What matters?* (NCJ 194077). National Institute of Justice.
- Rentoul, L. & Appleboom, N. (1997). Understanding the psychological impact of rape and serious sexual assault of men: A literature review. *Journal of Psychiatric and Mental Health Nursing*, 4, 267-274.
- Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.
- Stallard, P. (1996). The role and use of consumer satisfaction surveys in mental health services. *Journal of Mental Health*, 5, 333-348.
- Tjaden, P. & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. (NCJ 181867). National Institute of Justice.
- Tjaden, P. & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey*. (NCJ 210346). National Institute of Justice.
- United States Department of Justice. (2004). *Violence against women: identifying risk factors*. (NCJ 197019). National Institute of Justice.
- United States Department of Justice. (2004). *A national protocol for sexual assault medical forensic examinations, adults/adolescents*. (NCJ 206554). Office on Violence Against Women.
- Wasco, S.M. (2004). An ecological study of repeated sexual victimization among college women. (Doctoral dissertation, U Illinois At Chicago) *Dissertation Abstracts International*, 65 (3-B).
- World Health Organization. (2002). *World report on violence and health* Eds. E.G. Krug et al. World Health Organization, Geneva.
- World Health Organization. (2005). *Summary report: WHO multi-country study on women's health and domestic violence against women*. World Health Organization, Geneva.

“Treat men who are raped the same way women are treated...it WAS rape even if I was not penetrated in the vagina...special sensitivity is needed to LGBT issues (hate crimes) and someone to talk to you and comfort you.” —54-year-old male

We Need Your Help ► Because Sexual Violence Is Still a Problem.

The New York City Alliance Against Sexual Assault develops and advances strategies, policies and responses that prevent sexual violence and limit its destabilizing effects on victims, families and communities. As the only sexual violence organization in the country conducting primary research on sexual violence, we are in a unique position to raise public awareness and

create sustainable change. Our work is made possible by the generous contributions of people like you; people who share the commitment of engaging all communities in addressing sexual violence. Together we can ensure survivors of sexual violence receive the best care and dare to envision a world without sexual violence. All we need is you! Please give today.

Please select how you would like to direct your gift:

- ☐ **Give to the Alliance / Community Fund**
- ☐ Innovative Research
- ☐ Immigrant Women
- ☐ Youth
- ☐ Survivor Access to Best Care
- ☐ Training and Education
- ☐ Sexual Violence Resource Leader
- ☐ Legislative Advocacy
- ☐ Community Organizing
- ☐ SAYSO!

Please select your gift amount:

- ☐ \$25 ☐ \$50 ☐ \$100 ☐ \$250
- ☐ \$500 ☐ \$1,000 ☐ Other \$ _____

First Name _____

Last Name _____

Address _____

City _____

State _____

Zip _____

Daytime Phone _____

Email Address _____

Payment Method:

- ☐ Check or money order payable to the
New York City Alliance Against Sexual Assault

Credit card (check one)

- ☐ MasterCard ☐ VISA ☐ Amex ☐ Discover

Card number _____

Expiration Date _____

Today's Date _____

Name on Card _____

Billing Address ☐ same as opposite column

Address _____

City _____

State _____ Zip _____

I would like my contribution to be in honor of: _____

I would like my contribution to be in memory of: _____

Fax your completed form to **212.229.0676**
or mail it to:

New York City Alliance Against Sexual Assault
27 Christopher Street, 3rd Floor
New York, NY 10014

To learn more about the Alliance or to donate online,
please visit **www.nycagainsttrape.org**



New York City Alliance
Against Sexual Assault

2005–2007 NYC Alliance Against Sexual Assault

BOARD OF DIRECTORS

Jennifer Mercurio, Board Chair

Mary Anderson

Madeline Bryer

Larry Busching

Louise Friedman

Erica Garcia

Herbert Goodfriend

Nathan Lubow

Benedict Monachino

Kristina Pappa

Mel Schneiderman

Shirley Traylor

Hope Wachter

Susan Xenarios

NYC Alliance Against Sexual Assault

PROJECT STAFF

Deborah Fry: Research Director

Sam Nelson: Web Manager

Tamara Pollak: Training and Education Director

Jennifer Tierney: Communications Director

CONSULTANTS

Teresa Roman: Translator, Portada LLC

Scott Santoro / Worksight: Graphic Design Services



**New York City Alliance
Against Sexual Assault**

NYC Alliance Against Sexual Assault
27 Christopher Street
3rd Floor
New York, NY 10014
(212) 229-0345 phone
(212) 229-0676 fax
research@nycagainstrape.org
www.nycagainstrape.org